

THE IMPACT OF THE PHYSICIAN PRIMARY SPONSOR
PLAN ON THE MEDICAID PROGRAM
IN MICHIGAN

MPE 4.7

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EXECUTIVE SUMMARY

INTRODUCTION

The Physician Primary Sponsor Plan (PPSP) was designed and implemented by the Michigan Department of Social Services as a modification to the traditional Fee-for-Service (FFS) method of reimbursing physicians for health care services provided to public assistance clients. Under traditional FFS, clients have unrestricted choice among Medicaid providers and services are reimbursed based on Medicaid fee-for-service rates. Some hypothesize that this system of unrestricted choice leads to overutilization of health care services, and contributes to uncontrolled health care delivery, which often manifests itself in unnecessary, duplicative or contraindicated services and procedures. In the PPSP system, clients are required to select a single physician who acts as the sponsor physician and provides or authorizes almost all care received by the client. In return for this service, physicians receive a monthly case management fee of \$3.00 per enrolled recipient. As in the traditional FFS system, services are reimbursed on a fee-for-service basis.

METHODOLOGY

Three major research questions were assessed by the Health Care Alternatives study:

- o Does PPSP result in significant reductions in the number and cost of Medicaid services used by enrolled recipients?
- o What is the impact of PPSP on recipients' access to health care?

- o What is the impact of PPSP on clients' satisfaction with their health care and the care delivery system?

The study employed an experimental/control group design, where clients were randomly assigned to either PPSP or FFS. Sampling was done by selecting numerous independent samples based on clients' baseline utilization of doctor visits, prescriptions, laboratory tests, emergency room and inpatient hospitalization. Due to delays in enrollment and higher than expected sample attrition, these independent samples were aggregated into a single sample for analysis. This procedure does not conform to standard sampling practices; however, no bias was introduced and comparisons between PPSP and FFS groups should be valid and reliable.

Medicaid utilization and cost data were collected for the twelve months prior to enrollment in PPSP or assignment to the Control Group (baseline period) and for twelve months subsequent to enrollment or assignment (Experimental period). Only clients who remained eligible for assistance for the entire twenty-four months and stayed in either PPSP or FFS for twelve months after being enrolled or assigned were included in the final evaluation sample. Of 10,271 clients initially selected to be in the PPSP group, 3,065 (29.8%) were in the final sample. For the Control Group (FFS) 5,212 (52.2%) of those originally selected were included in the final sample. Almost all of the difference in sample attrition between the two groups is accounted for by recipients who were enrolled in PPSP and subsequently returned to unsponsored FFS. A separate analysis of these recipients showed no evidence of systematic

bias being introduced as a result of this large number of cases being excluded from the final sample.

In addition to utilization and cost data, two client satisfaction surveys were administered to a subsample of PPSP and FFS clients. The first questionnaire was administered at the end of the baseline period and the second after the expiration of the experimental period. The surveys were designed to gather information on clients' perceptions of access to care, quality of care received and satisfaction with health care.

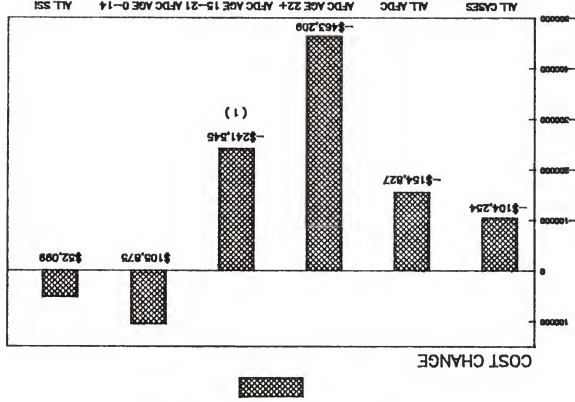
FINDINGS

Does PPSP result in significant reduction in the use and cost of health care?

For all recipients, PPSP resulted in significant net savings for recipients who had been medium and high users of services prior to enrollment. Reductions relative to FFS controls were found in doctor visits, laboratory tests, prescriptions and x-rays. Reductions in inpatient hospitalization were substantial, but not statistically significant. Gross program savings in total title XIX payments were \$147,254 per 1,000 recipients. Net savings after case management fees and administrative costs were deducted were approximately \$104,000 per 1,000 enrolled clients per year.

Further analysis indicated that program savings are not equally distributed across all client groups. As indicated in the chart on the next page, there were wide disparities in net change in expenditures between the subgroups analyzed. Slight increases in total expenditures were found for SSI clients and AFDC clients age 0-14. Total gross savings

NET CHANGE IN TITLE XIX EXPENDITURES PER 1,000 RECIPIENTS
(INCLUDES CASE MANAGEMENT FEES AND ADMINISTRATIVE COSTS)



(1) DOES NOT INCLUDE ANY SAVINGS FOR HIGH USERS. (NOT ENOUGH CASES)

for AFDC recipients age 15-21 were \$284,545 per 1,000 enrollees (\$241,545 net savings per 1,000). For AFDC clients over age 21 gross program savings were \$506,208 per 1,000 enrolled recipients, with net savings of \$463,209 per 1,000 enrollees per year.

For all AFDC recipients, including those age 0-14, the gross reduction in payments to providers was \$197,820 per 1,000 clients (\$154,827 net savings).

What is the effect of PPSP on access to care?

No meaningful differences between the PPSP and FFS groups were found. The percentages of respondents reporting positive and negative perceptions of access were very comparable in the baseline survey, and no significant shifts were found for either group on the experimental questionnaire.

What is the effect of PPSP on satisfaction with care?

General levels of satisfaction with care were quite high (3.5 to 4 on a five point scale) for both groups in the baseline period. As in the case of access to care, no meaningful positive or negative effect of PPSP was found in the experimental period survey, with a maximum net change in satisfaction of less than +.2 on a five point scale.

CAUTIONS

The evaluation results are reported only for clients who remained in the study for the full twenty-four months. The large number of clients

dropped from the study raise questions which cannot be fully answered in this study.

- o 1,327 clients dropped from the study because they returned to unsponsored care after enrollment in PPSP. Preliminary results indicate these clients tended to have established patterns of above average utilization and cost. If these results are borne out, significant program savings may have been lost due to the dropout process.

- o The clients included in the sample include significant numbers who were matched or blindly assigned to sponsors as the result of a failure to return the enrollment form or the selection of a physician who was not under contract as a sponsor. This process of matching and/or assigning was done only for clients selected for the PPSP sample, and was never done for the general Medicaid population. At this point, there is evidence to suggest that method of enrollment played some role in determining program impact, with greater savings for clients matched or assigned. Thus, if matching and assignment are not part of the PPSP program for the entire population, savings may be somewhat lower than those estimated in this study.

DISCUSSION

PPSP is a cost-effective means of controlling the utilization and cost of Medicaid services without significantly impacting access to care or client satisfaction. However, the data clearly indicate the need for further

discussion and consideration of issues surrounding PPSP and health care delivery in general. The wide variety of results found for subgroups of the population raises the issue of potential "targeting" of the program to AFDC recipients age 15 and over, for whom the program is cost-effective in the strictest sense. Alternatively, the data suggest a possible benefit in terms of increased care for AFDC children, which may be a desirable program effect given the low level of utilization of children relative to all other groups. Also, issues of program administration and provider desires must be considered in any decision about program modifications. Targeting the program would introduce considerably greater complexity and would represent a significant loss of Medicaid revenue for many health care providers.

Finally, the PPSP program as currently constituted does not effectively address the issue of provider initiated utilization. Without a system of standards, incentives and sanctions, considerable potential for Medicaid use and cost control may be left largely unrealized. Further, in the absence of a system of provider monitoring fully integrated with PPSP, it is not possible to assess the very important issue of case management versus gatekeeping.

Thus, it can only be concluded that PPSP succeeded in one of its major goals, that of reducing utilization and cost of Medicaid services. However, there is a clearly documented need for further refinement and modification, and an equally important need for further research into issues raised by this report and by the nature of the program itself.

I. OVERVIEW

A. Medicaid Finance and Delivery Alternatives

The four Medicaid finance and delivery alternatives discussed in this chapter are: Traditional Fee-for-Service (FFS), Health Maintenance Organizations (HMOs), Capitated Ambulatory Plans (CAPs) and Physician Primary Sponsor Plan (PPSP). They represent health care options with varying degrees of risk to the provider. Following is a brief description of FFS, HMOs and CAPs and their methods of setting prices, services provided, provider choice, and enrollment procedures.

The Physician Primary Sponsor Plan, designed by the Michigan Department of Social Services, and its implementation in Wayne County will be discussed in detail.

1. Traditional Fee-for-Service (FFS)

During the ten-year period prior to 1983, the number of eligible Medicaid recipients in Michigan increased by approximately 30%, while the costs of the Medicaid (MA) program more than tripled. Rising health care costs together with high unemployment and declining revenues have had an increasing impact on the state's ability to fund this program.

A major cause of the problem seems to be the fee-for-service health care delivery system. The traditional Medicaid fee-for-service structure provides eligible recipients with a card which guarantees health care at no cost to the patient. There are few limits placed on the number of

services that can be provided. The cost is charged to the Medicaid program based on the "customary fee", according to the Medical Services Administration screen or the fee the physician charges, whichever is lower.

Various methods have been used to contain costs, including decreasing the fees paid to physicians or holding them constant. As a result, physicians' fees are at pre-1977 levels. However, as reimbursement decreases, some physicians leave the Medicaid program or refuse to accept new Medicaid patients. In turn, patients may be forced to seek services from hospital emergency rooms and "high volume" clinics (clinics where physicians are making over \$100,000 from Medicaid).

There is general agreement among the state legislature, the medical community, and the Michigan Department of Social Services (MDSS) that less costly alternatives to the traditional fee-for-service structure must be employed, Health Maintenance Organizations (discussed later in this chapter) and the Recipient Monitoring Project are two such options. The latter was implemented in 1979 to control the highest utilizers of prescription drugs and emergency room services. Recipients in the project must have all ambulatory medical services pre-authorized. However, since only 2,500 recipients are monitored at any one time, this

approach cannot adequately address the problem of containing Medicaid costs generally.

Further, the Recipient Monitoring Project can do little about provider-initiated overutilization. Some providers have costs that far exceed their class group average, and the difference cannot be explained by case mix or patient population. Michigan has well-developed audit capabilities, but the need to demonstrate abuse and/or lack of medical necessity as well as a prolonged hearings process limit efforts to affect provider behavior through auditing.

2. Health Maintenance Organizations

Contracting with Health Maintenance Organizations (HMOs) for care of Medicaid recipients began in 1971. Currently, Michigan has contracts with seven HMOs, six serving in Wayne County.

An HMO is at the opposite end of the spectrum of risk to the provider from fee-for-service provision of health care. HMOs provide a comprehensive package of services and must be licensed by the Department of Public Health. Rates and financial viability come under the Insurance Bureau's purview. HMOs receive a capitated rate which is 90% of the age, sex, category of assistance and location-adjusted fee-for-service rate. Normally, HMOs do their own marketing and recipient enrollment although the workers in the

initial enrollment process of PPSP also processed enrollments in HMOs and CAPs.

Under Title XIX, the HMO can be cost settled (although there is a ceiling based on comparable fee-for-service costs) or at risk. Since 1980, Michigan has had a per person, risk only contract policy. There is no cost settlement at the end of the year if the HMO costs have exceeded their capitation fee. HMOs have been very successful in reducing utilization, particularly of inpatient hospital care. However, because of high start-up costs and the need for a large population base, HMOs are primarily confined to large urban centers.

3. Capitated Ambulatory Plan

The Capitated Ambulatory Plan (CAP) is a case management approach similar to an HMO. It is not, however, as comprehensive nor is there as much risk to the provider. Under the contract, the CAP agrees to provide or arrange for most Medicaid covered services to enrolled recipients. Exceptions are dental, hospitalization, long-term care and personal care. While CAPs are not at risk for hospitalization, they must authorize all non-emergency inpatient hospital care. CAPs do their own marketing and recipient enrollment and offer a coordinated approach to health care.

CAPs receive a capitation payment for each enrollee

during the month of service. It is based on age, sex, category of assistance and location-adjusted variables. The rate cannot exceed 100% of the fee-for-service costs for a similar population. In addition, hospital costs for the enrolled population will be projected and, if savings are realized, they will be shared with the CAPs.*

4. Physician Primary Sponsor Plan (Sponsored Fee-for-Service)

a. Description

The Physician Primary Sponsor Plan (PPSP) was developed in response to a provision in the FY 1982 Michigan Department of Social Services Appropriations Act (Section 68, P.A. 135 of 1981). Waivers of state-wideness, freedom of choice, information disclosures and the duration and scope of benefits were approved under section 1915 (b)(1) of the Social Security Act. It called for the establishment of an alternative system for reimbursing physicians, developed in conjunction with the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons. The proposal was presented to the Michigan State Legislature on August 6, 1981. The major goals of PPSP are to:

* A report that includes an analysis of the HMO and CAP data and the comparisons that can be made with FFS and PPSP will be available under separate cover.

- . Increase physician participation in Medicaid;
- . Maintain or improve recipient access to and quality of medical care;
- . Better manage recipient use of medical services;
- . Contain costs in Medicaid while paying equitable fees to physicians.

The objective of PPSP is to enroll AFDC and SSI recipients (excluding crippled children, long-term care, or Medicare eligibles) with an individual physician sponsor. The sponsor is responsible for providing care or giving prior authorization for services to recipients under his/her care.

Emergency care, vision, hearing, family planning in a family planning clinic, dental, podiatric and chiropractic services do not have to be authorized by the sponsor.

The primary aspects of PPSP are:

- o All physicians enrolled as participating physicians in the Medicaid program are eligible for participation in the program.
- o Sponsor physicians who sign contracts serve as case managers for all Medicaid recipients who elect to enroll with them. The sponsor physician is responsible for

providing primary care and for arranging and authorizing all other non-excluded services.

- o Sponsor physicians sign a contract agreeing to case management responsibilities. These include a 24-hour access arrangement and authorizing, locating, coordinating and monitoring all visits to other physicians, laboratory and pharmacy services, and hospital services (excluding specified emergency services). The sponsors are reimbursed on a fee-for-service basis and receive a case management fee of \$3.00 per month for the first 1,000 enrollees. No case management fee is paid after the first 1,000 enrollees. A sponsor may have no more than 2,000 enrollees although this limit may be exceeded to prevent disruption of existing doctor-patient relationships.
- o Sponsor physicians agree to review periodic reports on recipient utilization of services to help monitor patient care more effectively.
- o Sponsor physicians who exceed established standards by either individual service category or in total for their recipient population over a three-month period will be subject to sanctions. These include: warnings, reductions in case management fees and/or Medicaid reimbursement fees, and expulsion from PPSP. Discipline will be

administered by the State of Michigan in conjunction with a peer review committee.

PPSP was implemented July 1, 1982 following the issuance of explanatory program bulletins and the signing of physician contracts by more than 600 Wayne County physicians. However, implementation was stopped within two weeks by a temporary restraining order issued in response to a lawsuit filed by groups of physicians and Medicaid recipients. The charge was that PPSP violated Department of Social Services regulations by allowing physicians to be terminated as primary sponsors without first giving them a hearing when their patients over-utilized services. Some physicians also objected to the plan's original limit of 1,500 recipients per primary sponsor. The restraining order was lifted in October after the department agreed to adhere to existing due process procedures before terminating primary sponsors.

b. Physician Enrollment

During the initial months of PPSP, physicians applying for PPSP were presented with a contract. The majority received the standard contract, but a small number were classified as "provisional" based on a history of high utilization. The latter group received a slightly different contract with the provision that the case management fee would be held in escrow until their utilization pattern under PPSP was assessed.

If it was too high, the fee would not be paid. In addition, physicians were subject to sanctions for exceeding class group utilization levels subsequent to PPSP enrollment. This aspect of the plan, however, was not implemented and no sponsor physicians were ever sanctioned.

In August 1983, a new one-year renewable contract was sent to 1,300 Wayne County physicians. This included sponsor physicians enrolled in PPSP at that time, as well as other physicians who had expressed an interest in the program.

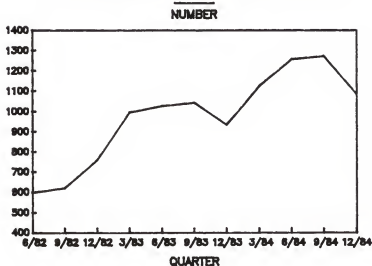
The number of sponsor physicians enrolled in PPSP at the end of each three month period from the beginning of the program to the end of 1984 is depicted in Figure I-1. The drop in number of enrolled physicians in December, 1983 and December, 1984 can be explained by the fact that October, 1983 and October, 1984 were the beginnings of new contract periods.

Recipients may request assignment to physicians who are not under contract to PPSP. When this occurs, a "marketing" letter is sent to the physician urging the physician to sign a PPSP contract. Physicians do have the option of refusing to accept new Medicaid patients, while allowing their current patients to enroll with

them as primary sponsors. Many physicians are not aware of that option, and do sign a PPSP contract after learning of it. The PPSP sponsor physician is paid a fee of \$3.00 per month for each active Medicaid recipient enrolled with that sponsor for the month.

TABLE I-1

PHYSICIANS ENROLLED IN PPSP



A provision of the PPSP contract is that the Department of Social Services provide to the physician a report of unusual utilization patterns exhibited by any recipient assigned to that physician. This quarterly utilization report was mailed to sponsor physicians for the first

time in September, 1983 and continues to date. Reports are generated only for recipients who demonstrate a utilization pattern that greatly exceeds the average. Sponsor physician response has been favorable. The report provides such information as the number of different providers the enrolled recipient is seeing and number of prescriptions received. If the utilization for the recipient appears questionable, the sponsor physician can request a claim detail report which gives more specific information to assist in making case management decisions.

Table I-1 represents the number of recipients enrolled in PPSP (those for whom case management fees are paid) by quarter.

TABLE I-1
Case Management Fees

	September 1983	December 1983	March 1984	June 1984	September 1984	December 1984
Recipients Fees Paid During The Quarter	18,219 \$131,529	21,863 \$187,345	35,908 \$300,645	46,095 \$366,600	53,940 \$472,158	56,102 \$494,391

c. Recipient Enrollment

The goal of PPSP is to enroll all Medicaid recipients in Wayne County who are not already enrolled in a Health Maintenance Organization (HMO), Recipient Monitoring or a Capitated Ambulatory Plan (CAP). Discussion of recipient enrollment will be divided into two sections: the initial enrollment process and the current enrollment process.

- i) Initial Enrollment Process: Initial projections, which proved unrealistic, were that all of the approximately 300,000 eligible MA recipients in Wayne County would be enrolled by December, 1983.

The design of the initial procedure was simple. A booklet was sent to eligible recipients at the rate of 1,000 per day. The recipients called to identify the sponsor physician with whom they wished to enroll, and the enrollment was processed.

A staff of "sponsor specialists" was established to process the enrollment of recipients in PPSP. These workers also processed enrollments in HMOs or CAPs if the recipient chose one of those alternatives. It was expected that most recipients would respond within the 15-day period after receipt of the brochure. Those not responding would be assigned to a sponsor physician in their geographic area.

The response rate of recipients was considerably below expectations. As mentioned previously, the temporary restraining order (TRO) filed by physicians in July of 1982 stopped PPSP implementation until the TRO was lifted in October, 1982. Prior to the TRO, less than 100 recipients had been enrolled. By December of 1983 only 19,100 (6%) of the approximately 300,000 eligible Medicaid recipients in Wayne County were enrolled in PPSP. Several changes were initiated to enhance the process. They were as follows:

- . A notice was included with the Medicaid Sponsor booklet, sent to clients emphasizing the importance of reading the booklet and contacting the MSA office. This step caused a slight increase in the response rate.

- . A second notice were sent to recipients who failed to respond to the booklet. This notice consisted of a letter reminding the recipients that they had received the brochure but had not responded. Included in this letter was the name of a sponsor physician to whom they would be "assigned" unless they responded within 15 days to select their own sponsor physician. This increased the response rate markedly. However, because this second notice had to be produced manually, it was too time consuming and the step was discontinued.

. A "computer-match" system was developed which identified sponsor physicians seen by a recipient during a recent six-month period. Recipients failing to respond to the booklet were enrolled with that sponsor physician with no prior notice to either the recipient or the physician.

. Medical Services Administration (MSA) assignments were instituted for those recipients who failed to respond to the booklet, and who had not seen a sponsor physician to be computer matched. "MSA" and the sponsor office phone number were printed on the recipient's Medicaid card instead of the name and number of a sponsor physician. In essence, MSA became the sponsor, and approval to provide non-emergency medical care was required. It was envisioned that at the time of contact for the treatment approval, the recipient would be asked to enroll with a sponsor physician.

Approximately 3,900 recipients were "blindly" assigned to sponsors after failing to respond to the booklet. The blind assignment was done only for research purposes and never for the general Medicaid population. Many of these recipients were unaware that an assignment had been made, and experienced problems when seeking medical care from a physician other than the one to whom they had been assigned. Since the location of the

assigned physician's office was not listed on the Medicaid card, some recipients did not know where to get care. In addition, attempts by non-sponsor physicians to obtain authorization for care for recipients was sometimes unsuccessful because sponsor physicians were uncertain about authorizing care for patients whom they had never seen.

The changes in the enrollment process resulted in administrative complexities which caused enrollment to proceed at a slow rate. The "MSA" designation proved unworkable for two major reasons. It generated an enormous volume of phone calls which staff were not able to process. Constantly busy phone lines resulted in a few recipients being denied medical care. It also prevented recipients from attempting to enroll through the normal channel which in turn increased the "blind" assignments and the "MSA" assignments.

This unanticipated delay in recipient enrollment did have some positive results. It allowed time for the impact of PPSP enrollment methods on recipients to become more evident before adversely affecting large numbers of recipients. It also led to the evolution of a more streamlined approach to enrollment.

- ii) Current Enrollment Process: In an effort to increase the enrollment rate, two major changes were implemented early in 1984: first, the enrollment of recipients is handled through the mail rather than by telephone; second, the Medicaid Sponsor Office in Wayne County was supplemented by a staff located in Lansing.

The "new" process offers three methods by which recipients can be enrolled in one of the health care alternatives.

- . Recipient Mail-in Enrollment: Medicaid recipients were mailed a notice (Exhibit I-1) in March, 1984, with their Medicaid cards. This notice briefly described the health care options available to Wayne County Medicaid recipients. It also provided a form which could be used to request more information on any or all of them, or to request an enrollment form. Recipients were sent information sheets on PPSP (Exhibit I-2), CAP (Exhibit I-3), and/or the HMO booklet (Exhibit I-4). An enrollment form (Exhibit I-5) was also enclosed. After reviewing the information, if the recipient chooses to enroll in one of the alternatives, the enrollment form is completed and returned directly to the Lansing enrollment office for processing.

. Local Social Service Office Enrollment: Each head of household is seen at least once a year either at the time of intake for public assistance or when a re-determination of public assistance eligibility is completed on the case. At that time, the Assistance Payments (AP) worker will assist the recipient in completing the enrollment form which will then be sent to the Lansing enrollment office for processing. This method was phased in during the first half of 1984.

. Physician Initiated Enrollment: The physician associations were instrumental in designing, printing, and distributing an enrollment booklet (Exhibit I-6) for their use. All sponsor physicians who have contracted with PPSP receive a supply of the booklets to distribute to their Medicaid patients. Recipients can use the enrollment portion of the booklet to enroll in one of the alternatives or to request more information. If information is requested, the recipient mail-in process is followed.

All requests, whether for enrollment or for information, are sent to the Lansing enrollment office for processing.

It is important to note that PPSP as it developed is not a fully mandatory system, but a partially

mandatory program. That is, while there were mandatory assignments and computer/match methods employed, recipients had only to request assignment to another physician if they were dissatisfied with their physician sponsors. This often meant that the recipient request for another physician resulted in a considerable drop-out rate from PPSP back to the traditional fee-for-service system. By December of 1984, 56,100 (19%) of the eligible Medicaid recipients were enrolled in PPSP. As of June, 1986 there were approximately 82,000 Medicaid recipients enrolled in PPSP. Another 85,000 were enrolled in HMOs and 1,100 in CAPs. These numbers represent approximately 50% of the eligible Medicaid population in Wayne County.

d. Reaction of Providers

- i) Participating Physicians: There are approximately 20,000 licensed physicians in Michigan, 12,000 of whom are in Wayne County. Although approximately 3,000 Wayne County physicians meet the definition of a primary care sponsor, 1,273 actually signed contracts to participate in PPSP for the second year. As of June, 1986 the average number of PPSP patients per primary sponsor was seventy-three. The median was twenty-one. Two hundred and eleven (211) physicians had more than 100 PPSP patients enrolled.

- ii) Survey of Physicians: Professor Theodore Goldberg, Chairman of Community Medicine at Wayne State University, conducted a survey of physicians in August, 1982. The content of the questionnaire focused on their perceptions of the Medicaid program and knowledge and perception of PPSP. The survey was mailed to a 25% random sample of physicians practicing in Wayne County or in zip codes contiguous to Wayne County, resulting in a sample size of 1,292 physicians. After the initial mailing, follow-up mailing and telephone contacts, a final sample of 441 usable questionnaires were completed. An analysis of physician characteristics indicated that physicians enrolled with Medicaid were much more likely to respond than were non-enrolled physicians. No other factor seemed to be significantly associated with the likelihood of responding. A copy of the survey and introductory letter is found in Appendix A. Table 1-2 summarizes physician and practice characteristics among respondents. Among the survey findings were:
- . Fifty-one percent of the physicians feel Medicaid clients use more health care than non-Medicaid clients.
 - . The major reasons given for overutilization are: no cost, overuse of ER and inpatient care and doctor shopping.

- . Fifty-five percent of the physicians feel that Medicaid clients have a greater need for medical care.
- . Ninety percent of the physicians were familiar with the PPSP program on at least a conceptual level.
- . Fifty-two percent of the physicians liked the provision that they would be their PPSP patients' sole sponsor for authorization of all medical treatment.
- . Among the physicians' projected effects of PPSP:
 - 50% - decreased utilization
 - 52% - reduced hospitalization
 - 69% - reduced ER use
 - 91% - reduced doctor shopping
 - 76% - reduced Medicaid abuse
 - 63% - reduced total Medicaid cost
 - 61% - increased government involvement

These results indicated support for the PPSP program in the physician community and the expectation that PPSP would reduce Medicaid costs. A second survey was to have been conducted to assess physician attitudes after experience with PPSP. Due to funding and resource constraints, this survey was not done.

TABLE 1-2

Characteristics of Responding Physicians

<u>Sex</u>		<u>Type of Practice</u>	
Male	88%	Solo	38%
Female	12%	Partnership	21%
		Private Group	22%
<u>Age</u>		Prepaid Group	8%
20-29	2%	Industry	3%
30-39	25%	Hospital Based	3%
40-49	35%	Hospital Employee	2%
50-59	24%	Public Health	2%
60-69	13%		
70+	2%	<u>Speciality Status</u>	
<u>Number of Offices</u>		General Practice	25%
One	71%	Speciality	75%
More than one	21%		
<u>Patient Mix</u>		<u>Practice Speciality</u>	
Mostly lower income	24%	Family/General	53%
		Emergency	3%
Mostly lower, with middle and upper	35%	Surgery	5%
		Internal Medicine	19%
Mostly middle with lower and upper	30%	OB/Gyn	10%
Mostly middle income	11%	Pediatrics	9%
		Psychiatry	1%

e) Reaction of Recipients

The PPSP Monitoring Project was established to monitor implementation of PPSP with particular attention to its impact on Medicaid recipients. The project is being conducted by the Michigan League for Human Services (MLHS) under a grant from MDSS. The league is a non-profit planning and research organization supported by the United Way of Michigan.

A Monitoring/Evaluation Committee was established with representatives from the Medical Services Administration (MDSS), the Office of Planning, Budget and Evaluation (MDSS), Wayne County Department of Social Services, House and Senate Legislative staff, physician groups, health maintenance organization, Medicaid recipients, and advocacy groups. Immediate feedback is provided to MDSS, the PPSP Steering Committee, and the Michigan Legislature to assess whether PPSP is being implemented as intended, as well as its effect on recipients, providers, and the community.

The Monitoring Project has been instrumental in identifying problems in three areas: (a) information to recipients and providers, (b) recipient health care access, and (c) insufficient staff support for PPSP administration/operations. Their conclusions based on surveys:

a) Information

Several recipients expressed a desire for more information in these specific areas: referrals, authorizations, use of emergency rooms, the role of pharmacies, options for changing sponsors, and selection of different sponsors for different family members.

b) Access

Recipients who have positive, long-standing relationships with physicians who have enrolled as sponsors, and recipients who have reasonable access to transportation, have fewer problems under PPSP.

. There is a lack of understanding on the part of both providers and recipients about procedures for seeking, authorizing, and/or referring care under PPSP.

. Some necessary referrals are not being made by sponsor physicians. Data from the Monitoring Project's surveys between 1983 and November 1985 show an impressive consistency in the area of sponsor referrals to specialists; 30 percent of enrollees requested such a referral, and roughly one in five were not assisted by their sponsor physicians to access this specialty care. In the matter of referrals for second opinions, a service which the sponsor is required to perform under his or her contract, of the one in ten PPSP enrollees who requested a second opinion in 1983 and 1984, 25 percent were not assisted.

It is possible that physicians' perception that Medicaid recipients overutilize services may in some cases be affecting their willingness to make referrals. The pre-PPSP physician survey mentioned elsewhere showed that 51 percent of respondent physicians believed that Medicaid patients utilized services more frequently than other patients.

.Twenty-four hour access is not available for some recipients, either because the sponsor does not provide it or because the recipient lacks the information to use it. MSA clarifications require that sponsors have their office telephone numbers, which are printed on the restricted MA cards, tied into an answering service during non-business hours; this service must be in contact with the sponsor or an alternate. Consistently, however, the Monitoring Project's surveys show that between 20 and 25 percent of respondents who tried to contact their sponsors during off hours were unable to do so.

c) Staff

From the beginning, clerical and technical

support has been insufficient, and the professional staff are required to perform these functions. This limits the time available to handle phone calls pertaining to enrollment, information, and problem solving. The result is that both recipients and providers have had difficulties contacting the staff, which has led to problems in accessing appropriate care.

f. Reaction From Providers, Organizations, and Community Groups

The major emphasis of the Monitoring Project is directed toward the effect PPSP has on recipients. However, a study of the reactions of providers, organizations and community groups is also being conducted.

Several issues of concern have been identified, most of which indicate a general lack of understanding of PPSP by both providers and recipients. They include:

- . Some hospitals are contacting sponsor physicians after-the-fact to obtain authorizations for non-emergency care.
- . Clinic and hospital emergency room staff must cope with angry recipients who have to wait until their sponsor physician is contacted for authorizations.

- . Assignments to sponsor physicians cause problems, both for the recipients newly assigned to a physician and to a physician's regular patients who have been assigned elsewhere.

- . Pharmacists are hesitant (some refuse) to fill prescriptions which were not written by the sponsor physician, even though they have been informed by MSA that this is allowed.

A report detailing the work and findings of the Monitoring Project is included in Appendix B.

B. Prior Research On Utilization of Medical Services

1. Introduction

There is increasing interest in understanding utilization of medical services. In Michigan, this interest is predominantly motivated by the increasing cost of medical care and, more specifically, the growing percent of the state budget which is spent on Medicaid expenses. The cost for the nation's personal health care continues to increase at a rapid rate. In 1978 the total cost at the national level was \$165.5 billion. By 1982 that figure was \$287 billion, a 73% increase.

2. National Picture

In a 1982 survey, findings showed that the average American will visit a physician five times a year and receive slightly more than four prescriptions.

Approximately 15% of the population will be hospitalized for an average of 8 days. A small fraction of the population will use the emergency room for emergency services. Very little is known about the usage of laboratory tests.¹

3. Michigan Picture

The information available on the average Michigan citizen suggests that Michigan approximates the national picture for average office visits per year and length of stay in hospitals. In southeast Michigan (Wayne, Oakland and Macomb Counties) there appears to be a longer average length of stay in hospitals (8.6 days in 1982 rather than 7.6 days nationally).

MDSS prepared a profile of Michigan Medicaid recipient utilization in 1980. Use of medical care was determined for recipients of various public assistance programs. This study found an average of five doctor visits (office visits and outpatient non-emergency visits per year) with eleven prescriptions per year. Approximately 22% of Medicaid enrollees were hospitalized. Thus, the average Medicaid client in Michigan has a higher use of both prescriptions and hospital admissions. Table I-3 summarizes statistics kept by the MDSS Data Reporting Section on the Michigan Medicaid population and expenditures for four of the five years.

¹ "The National Medical Care Expenditure Survey" (NMCES), National Center for Health Services Research, Department of Health and Human Services.

previous to the introduction of PPSP under the traditional fee-for-service (FFS) system. The data is missing for 1981 due to a computer problem. A more detailed description of the specific Medicaid sub-population targeted for this study will be provided later in the report.

TABLE 1-3
Michigan Medicaid Recipients and Expenditures
1978 - 1980, 1982

	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1982</u>
Number of Medicaid Recipients	911,932	897,666	973,443	1,174,833
Dollars Spent	\$901,035,338	\$1,036,401,675	\$1,071,680,997	\$1,292,630,601
Average Dollars Per Recipient	\$ 988.05	\$ 1,154.55	\$ 1,100.92	\$ 1,100.27

Total expenditures in 1982 were over 391 million dollars more in 1978, an 11% increase. The number of recipients, however, increased by almost 263,000 between 1978 and 1982, and the inflation rate grew. These figures, therefore, indicate a decrease in actual dollars spent.

Further discussion of previous research on national and Michigan utilization patterns and access to care can be found in Appendix B of this report.

C. Satisfaction With Medical Care

1. Introduction

The measurement of patient satisfaction has been the topic of many studies within the health care system during the last twenty-five years. The general increase in consumer consciousness has led to an increased interest on the part of the medical profession to examine the attitudes and characteristics of their patients. Research techniques used in patient satisfaction surveys have been criticized for lacking a sound empirical foundation. However, this research has become much more sophisticated and is making a significant impact on the health care system. Appendix C provides an overview of the research on this topic under several major headings, including the purpose, method, and general findings.

2. The Major Dimensions of Patient Satisfaction

Patient satisfaction is a multi-dimensional concept. Eight distinguishable dimensions of patient satisfaction have been identified (Ware, Davies-Avert, and Steward, 1978). They are presented here in the order of the frequency in which they were measured in the surveys on patient satisfaction summarized in this report. The major satisfaction dimensions are:

a) Art of Care - The amount of "caring" shown towards patients, an aspect of provider conduct.

b) Technical Quality of Care - The competence of provider,

their adherence to high standards of diagnosis and treatment. Again, an aspect of provider conduct.

- c) Accessibility/Convenience - The factors involved in arranging to receive medical care, including distance, ease of travel, waiting time, and time required to schedule an appointment.
- d) Finances - The ability to pay for services or to arrange for payment, including flexible payment mechanisms and insurance coverages.
- e) Physical Environment - The environment of care, including general pleasantness, comfort, waiting room lighting, and quiet and orderly facilities.
- f. Continuity of Care - The regularity of care from the same facility or provider.
- g. Efficacy/Outcomes - The perceptions regarding the usefulness or helpfulness of medical care provider.
- h) Availability - The amount of medical care resources in the community.

Table 1-4 shows a comparison of scores on five satisfaction dimensions of the traditional fee-for-service, PPSP, and HMO

TABLE I-5
Comparison of Satisfaction Dimensions

Satisfaction Measures	Question Numbers	CHAS-NORC ^A	PHRED ^D	BASE	FFS EXP	BASE	PPSP EXP	HMO
General Satisfaction ^C	1,7*,12,17*	3.27	3.35	3.42	3.40	3.39	3.37	3.31
Accessibility/Convenience	2*,4,8*,11*,19,20*	3.24	3.43	3.47	3.50	3.45	3.46	3.42
Art of Care	3,18*	3.52	3.70	3.84	3.80	3.78	3.75	3.67
Technical Quality of Care	5*,16	3.09	3.48	3.53	3.53	3.51	3.44	3.53
Physical Environment	14*	3.31	3.56	3.52	3.44	3.54	3.39	3.52
Satisfaction Total	A11 15	3.27	3.46	3.52	3.51	3.49	3.47	3.45

*These were negative statements, so the responses have been reversed to show the positive results.

^ACenter for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), 1976.

^DPrepaid Health Research, Evaluation, and Development Project (PHRED), California State Department of Health Services, 1979.

^CExcept for General Satisfaction, only some items in each of the satisfaction measures were identical in the 1979 and national surveys. Scores were computed by summing item scores for matching items.

samples used in this study with scores from two national surveys. The satisfaction scores of the study's samples do not vary significantly from those of the national surveys. Further discussion of the client satisfaction survey employed in this study can be found in the last chapter of this report.

D. Medicaid Policy Changes

There were several program changes which took effect before and during the baseline and experimental periods of PPSP. Following are some of the program changes that occurred, and their possible affects on PPSP.

1. Prior to the study period Medicaid disallowed payments to hospital emergency rooms for non emergency services. This policy had the effect of reducing emergency room utilization for the entire Medicaid population.
2. At about the same time as clients were being enrolled in PPSP, Medicaid announced a program of audits of providers who had exceeded the limits for the number of laboratory tests ordered on a per patient basis. The effect of this program was to cause substantial reduction in the number of tests ordered for high using clients, but an increase in the average number of tests for clients with no lab tests or a medium number of lab tests.
3. Another effect which must be considered is the effect

of focusing upon case management in Wayne County. Physicians probably paid more attention to the usage pattern of all their patients and not just their PPSP enrollees.

4. On October 1, 1984 prior authorization for all elective hospital admissions was implemented. This had the effect of reducing hospitalization across the board and not just for PPSP enrollees.
5. Also on October 1, 1984 an Expanded Second Surgical Opinion List was implemented for both inpatient and outpatient services. Again, the effect would reduce the amount of services provided for the entire Medicaid population.
6. PPSP enrollees do not have to pay a pharmacy copayment, while traditional fee-for-service recipients do. Medicaid thus pays more for PPSP recipient pharmacy use than it does for traditional fee-for-service.

II. RESEARCH DESIGN AND METHODOLOGY

A. Hypotheses

As noted in Chapter I, the purposes of the PPSP program were to reduce the utilization and cost of health care services while maintaining or improving access to and quality of care. The specific hypotheses to be tested were:

1. Decreased client choice as a result of sponsored care will lead to a net reduction in per patient health care cost.
2. There will be net reductions in the number of health care services used under sponsored care, specifically:
 - a. A reduced number of inpatient hospital days and inpatient hospital admissions.
 - b. A reduced number of emergency room visits.
 - c. A reduced number of prescriptions.
 - d. A reduced number of laboratory tests.
 - e. A reduced number of physician visits.
 - f. A reduced number of different physicians visited per quarter.

This report addresses both primary hypotheses and all specific hypotheses under (2), except (f). Limitations on data available made it impossible to obtain the information necessary to assess the number of different physicians seen over the tenure of the study.

B. Research Design

The research design for the PPSP study is a Pretest-Posttest Control Group design. Clients were sampled from that portion of the Wayne County Medicaid population which was potentially eligible for PPSP and were then randomly assigned to either PPSP or Conventional Fee-for-Service (FFS). Differences between the two groups in utilization and cost of health care services in both the baseline (12 months) and experimental (12 months) periods were assessed.

C. Sampling

The population from which the sample was selected consisted of all Wayne County Medicaid recipients who:

1. Were in programs C (AFDC), B (Blind) or E (Disabled).
2. Were not in long term care.
3. Were not enrolled in an HMO or CAP.
4. Had been continuously eligible for Medicaid for 12 months immediately prior to sampling and enrollment.

Of the entire Wayne County Medicaid population, 126,703 out of approximately 250,000 recipients satisfied the above criteria and were identified as potential study clients.

As indicated by the hypotheses, the project was initially intended to assess the impact of PPSP on five utilization variables:

1. Doctor Visits

2. Prescriptions
3. Laboratory Tests
4. Emergency Room Visits
5. Inpatient Hospitalization

The first step in the sampling process was to randomly divide the population into potential PPSP and FFS clients. This was done to preclude an individual being assigned to the experimental(PPSP) condition for one variable and the control (FFS) condition for another.

In order to assess each of the five variables separately, and to ensure an adequate number of cases were sampled for each, it was decided to use a stratified sampling design. Samples were selected independently for each of the five utilization variables, with strata corresponding to none, medium and high utilization. This stratification was done for all variables except hospitalization, which was not stratified. An assessment of the distribution of utilization of the population of 126,703 for the twelve months immediately prior to sampling led to the following strata cutoff levels.

	Doctor Visits	Prescriptions	Laboratory Tests	Emergency Room
None	0	0	0	0
Medium	1-15 visits	1-41 prescriptions	1-17 tests	1-2 visits
High	16 + visits	42 + prescriptions	18 + tests	3 + visits

The entire population was divided into the above strata and a random experimental and control samples were pulled for each variable and level of utilization. The resulting sample is displayed in Table II-1.

For numerous reasons, the above design proved unsatisfactory for the final analysis. Those reasons include:

1. The sample was drawn in May, 1983 and enrollment of clients was to take place in June, 1983, with the experimental period extending through May, 1984. Actual enrollment of experimental clients into PPSP did not occur until January-March, 1984, with the experimental period extending through February, 1985. Thus, the problem of people dropping out of the study was considerably exacerbated, and the original sampling scheme would have resulted in an insufficient number of cases to carry out the planned analysis.
2. Since clients were not enrolled until several months after stratification and selection, it was necessary to restratify the sample based on the 12 months of utilization immediately prior to enrollment. Thus, individuals "moved" from one stratum to another, and the resultant sample may not be viewed as truly random. The most notable shifts had the effect of substantially decreasing the size of the "none" and "high" strata, with corresponding increases in the "medium" level of utilization.

TABLE II-1

PPSP INITIAL EVALUATION SAMPLE

VARIABLE	USER GROUP	FREQUENCY OF USE	POPULATION		SAMPLE	
			POPULATION (N=126,703)	PERCENT OF POPULATION	PPSP (N=10,271)	FFS (N=9,981)
1. DOCTOR VISITS	NONE	0	23,759	18.8%	893	881
	OTHER	1-15	96,811	76.4%	940	955
	HIGH	16+	6,133	4.8%	753	784
2. PRESCRIPTIONS	NONE	0	30,130	23.8%	906	917
	OTHER	1-41	90,741	71.6%	944	859
	HIGH	42+	5,832	4.6%	750	800
3. LABORATORY TESTS	NONE	0	74,786	59.0%	949	867
	OTHER	1-17	44,590	35.2%	892	849
	HIGH	18+	7,327	5.8%	831	809
4. EMERGENCY ROOM	NONE	0	100,467	79.3%	738	670
	OTHER	1-2	23,650	18.6%	626	634
	HIGH	3+	2,586	2.1%	796	790
5. INPATIENT HOSPITAL *	ALL		126,703	100.0%	1099	1034

1 Based on an eligible population of 126,703, which represents all ADC, Blind and Disabled Medicaid recipients in Wayne County who had been continuously eligible for 12 months prior to April, 1983. Stratification of utilization for this population is based on data for the period April, 1982 through March, 1983.

* Not stratified since only 3,277 were hospitalized more than once.

3. The initial sampling design made no provision for looking at variables other than the initial five, nor did it allow for an analysis of total Medicaid expenditures.

Due to the higher than expected sample attrition, and to a need for more detailed analysis, it was decided to include all sample cases in the analysis of each utilization variable, thus substantially expanding the sample available for each analysis. While this was a necessary step, it has the effect of complicating the sample considerably. Since a given individual had several potential points of selection (i.e., the five utilization variables), and since individual levels of utilization vary across the five variables, recipients had unequal and unknown probabilities of selection. However, the initial split into PPSP and FFS was done randomly, since the sample procedures were followed for both groups, so systematic bias between the PPSP and FFS groups should not be a problem. However, some caution should be exercised in making inferences back to the general Medicaid population.

Of the initial sample of 20,252 (10,271 PPSP, 9,981 FFS), 14,114 were actually enrolled in PPSP or designated in the Control group in time to be included in the study. Those not included (a) were never enrolled in PPSP or designated in the Control group, (b) were enrolled in PPSP after March, 1984, (c) were not continuously eligible for Medicaid for twelve months prior to enrollment or designation or (d) were those for whom data was not available.

Table II-2 summarizes the processes by which the final evaluation sample was derived. It should be noted that, of those actually enrolled, 67.0% of the FFS group are included in the final sample while for the PPSP group the figure is 48.3%. The difference between the two groups is almost entirely accounted by PPSP clients who returned to unsponsored care after enrollment in PPSP. Of the enrolled sample of 6,340, (1,327 (20.9%) were lost in this manner.

Table II-3 displays comparisons of average total baseline payments for clients initially enrolled or designated, sample dropouts and the final evaluation sample. The data indicate differences between the PPSP and FFS groups were not substantial. Among high users, PPSP dropouts had \$98.96 higher payments for ambulatory services than dropouts from the FFS sample. In total payments, the difference is less than \$60.00.

A separate analysis of PPSP enrollees who returned to unsponsored care (FFS) revealed several important findings. Clients who returned to conventional FFS were significantly more likely to be high users of prescriptions and laboratory tests and were more concentrated in the 15 to 21 and 22+ age groups. Further, recipients dropped from the evaluation sample because of a return to FFS had substantially higher average total payments in the baseline period than those clients who remained in PPSP throughout the study. Among medium users, average total payments were \$513.69 higher for clients returning to FFS than for clients remaining in PPSP. For high users, the difference was \$1,093.94.

TABLE II-2

FINAL EVALUATION SAMPLE

	PPSP		FFS	
1. RECIPIENTS IN ORIGINAL SAMPLE	10271	100.0%	9981	100.0%
2. NOT IN SAMPLE: NOT ENROLLED ON TIME, NOT CONTINUOUSLY ELIGIBLE IN BASELINE, MISSING	3931	38.3%	2207	22.1%

3. RECIPIENTS ACTUALLY ENROLLED ON TIME	6340	61.7%	7774	77.9%
4. BECAME INACTIVE AFTER ENROLLMENT	1339	21.1%	1605	20.6%
5. ASSIGNED TO RECIPIENT MONITORING	3	0.0%	3	0.0%
6. ENROLLED IN HMO	504	7.9%	618	7.9%
7. ENROLLED IN CAP	38	0.6%	44	0.6%
8. PPSP RETURNED TO FFS	1327	20.9%	----	----
9. OTHER (LONG-TERM CARE OUT OF WAYNE COUNTY, ETC.)	64	1.0%	292	3.8%
10. FINAL EVALUATION SAMPLE	3065	48.3%	5212	67.0%

a ONLY PPSP RECIPIENTS ENROLLED 1/84 - 3/84 WERE INCLUDED IN THE SAMPLE

b PERCENTAGES FOR ITEMS 4-10 ARE OF THOSE ACTUALLY ENROLLED ON TIME (PPSP=6340 FFS=7774)

TABLE II-3
COMPARISON OF ENROLLED SAMPLE, SAMPLE DROPOUTS AND FINAL SAMPLE

		ENROLLED SAMPLE	SAMPLE DROPOUTS	FINAL SAMPLE	%DIFFERENCE
A. BASELINE AMBULATORY SERVICES PAYMENTS					
NON USERS	PPSP	\$108.56 (N=957)	\$127.28 (N=500)	\$88.08 (N=457)	-18.9%
	FFS	\$172.30 (N=1252)	\$130.02 (N=440)	\$195.21 (N=812)	+13.3%
MEDIUM USERS	PPSP	\$561.49 (N=4616)	\$590.96 (N=2374)	\$520.29 (N=2242)	-5.6%
	FFS	\$473.80 (N=5527)	\$441.46 (N=1827)	\$489.77 (N=3700)	+3.4%
HIGH USERS	PPSP	\$2056.34 (N=767)	\$2202.02 (N=401)	\$1896.73 (N=366)	-7.8%
	FFS	\$2063.91 (N=995)	\$2103.16 (N=295)	\$2047.37 (N=700)	-0.8%
B. BASELINE TOTAL PAYMENTS					
NON USERS	PPSP	\$172.96 (N=957)	\$182.79 (N=500)	\$162.21 (N=457)	-6.2%
	FFS	\$270.52 (N=1252)	\$236.84 (N=440)	\$288.77 (N=812)	+6.7%
MEDIUM USERS	PPSP	\$1146.31 (N=4616)	\$1199.99 (N=2374)	\$1089.47 (N=2242)	-5.0%
	FFS	\$1141.41 (N=5527)	\$1105.38 (N=1827)	\$1159.20 (N=3700)	+1.6%
HIGH USERS	PPSP	\$4430.38 (N=767)	\$4708.20 (N=401)	\$4125.99 (N=366)	-6.9%
	FFS	\$4458.38 (N=995)	\$4765.19 (N=295)	\$4329.08 (N=700)	-2.9%
C. BASELINE NUMBER OF DOCTOR VISITS					
MEDIUM USERS	PPSP	5.45 (N=4616)	5.47 (N=2374)	5.43 (N=2242)	-0.3%
	FFS	5.49 (N=5527)	5.29 (N=1827)	5.59 (N=3700)	+1.8%
HIGH USERS	PPSP	27.32 (N=767)	28.84 (N=401)	25.65 (N=366)	-6.1%
	FFS	27.11 (N=995)	27.06 (N=295)	27.13 (N=700)	+0.1%

Thus, clients who returned to FFS tended to be older and to have established histories of higher than average utilization and cost.

Finally, an analysis of average total payments for the baseline and experimental periods for clients who returned to FFS indicates that among medium users, the baseline to experimental change in total payments was + 1.5% for dropouts to FFS versus 5.3% for continuous PPSP clients and +7.9% for continuous FFS recipients. For high users, the dropouts to FFS experienced a 23.9% drop in total payments, compared to a 23.2% decrease for PPSP clients and a 4.6% drop for FFS clients. These data indicate that clients did not return to unsponsored care for purposes of securing high cost care (e.g. high risk pregnancy monitoring) or as the result of a catastrophic illness. If that had been the case, we would have expected substantially higher increases in experimental period costs for the group of clients returning to FFS.

In summary, at this point there is no clear evidence to suggest that the large number of cases returning to unsponsored care after PPSP enrollment introduced a significant systematic bias in either direction.

More significant is the percent of sample clients dropping out. Among high users, PPSP clients were 23% more likely to drop out, while for medium users, the difference is 18%. Thus, the ease with which clients could drop out of sponsored care has

significant implications for program savings. To the extent that clients drop out of PPSP, and savings from the program are realized for clients remaining in PPSP, total program savings are reduced.

Since sample recipients were required to remain on assistance for the full 24 months of the study period in order to remain in the study, and since PPSP clients were further required to remain in sponsored care for 12 months after enrollment in order to be included in the sample, the sample is not completely representative of the general Medicaid population. Further, since results are reported only for those recipients who remained in PPSP for 12 months subsequent to enrollment, the findings are valid only for a program in which the relatively easy option of returning to unsponsored FFS does not exist. To the extent that the program allows this option, projected program savings must be modified.

D. Data Sources and Collection

1. Utilization and Cost

Data on the utilization and cost of health care services was obtained from Medicaid paid claim records, which retain detailed information for each discrete service rendered to a client. As noted elsewhere, the periods studied are from 12 months prior to enrollment (Baseline) and from enrollment to 12 months after (Experimental). Specifically, the time periods for each group were:

	<u>Baseline</u>	<u>Experimental</u>
FFS (Control Group)	Jan.-Dec. 1983	Jan-Dec. 1984
PPSP (January, 1984 Cohort)	Jan.-Dec. 1983	Jan.-Dec. 1984
PPSP (February, 1984 Cohort)	Feb. 1983 - Jan. 1984	Feb. 1985 - Jan. 1985
PPSP (March, 1984 Cohort)	Mar. 1983 - Feb. 1984	Mar. 1984 - Feb. 1985

Thus, the Baseline and Experimental periods for the FFS and PPSP groups are not totally comparable. However, a check of general trends in per recipient Medicaid expenditures does not show substantial differences between the January-February, 1984 and January-February, 1985 periods. Thus, the non equivalence of study periods imposes no bias on the findings.

Data was collected on all services covered for by Medicaid and was acquired only after the expiration of the allowed 12 month billing lag to ensure completeness. Thus, final experimental data for the March, 1984 PPSP cohort was not collected until March, 1986.

Additional information on client demographics, eligibility, program, etc., was gathered from the Department's Client Information System (CIS).

For the purposes of this study, access to and satisfaction with medical care will be measured by the PHRED questionnaire. The survey was developed in California over a seven year period and has items which are identical to the CHAS-NORC

national study. A copy of the questionnaire is shown in shown in Exhibit I-9.

Demographics and health care access experiences are included in addition to eight health care dimensions. They include:

- . continuity of care
- . accessibility/convenience
- . physical environment
- . art of care
- . technical quality of care
- . efficacy/outcomes
- . general satisfaction
- . availability

The four dimensions of access to care include:

- . travel time
- . appointment wait
- . office wait
- . have regular doctor

Results from the samples used by CHAS-NORC for their national estimates and the PHRED project are included in the findings section of this report.

E. Methodology

The principal means employed to test PPSP program impact

involved the calculation of double differences, which are a measure of the net change in utilization, cost or satisfaction which could be attributed to PPSP. For example, in Table ALL-1, Appendix D, the following base-line number of doctor visits are found:

	PPSP	FFS
Non-Users	0	0
Medium Users	5.43	5.59
High Users	25.65	27.13

In the experimental period, the corresponding number of doctor visits were as follows:

	PPSP	FFS
Non Users	1.51	1.62
Medium Users	4.81	5.68
High Users	16.27	24.52

Thus, the changes (single differences) were:

	PPSP	FFS
Non Users	$1.51 - 0 = +1.51$	$1.62 - 0 = +1.62$
Medium Users	$4.81 - 5.43 = -.62$	$5.68 - 5.59 = +.09$
High Users	$16.27 - 25.65 = -9.38$	$24.52 - 27.13 = -2.61$

The effect (double difference) was thus:

Non Users	$1.51 - 1.62 = -.11$
Medium Users	$-.62 - .09 = -.71$
High Users	$-9.38 - (-2.61) = -6.77$

In addition to t-tests, nonparametric tests (Medians test, Kruskal-Wallis) were employed to further verify the significance of program impact when extreme variability of data made t-tests inappropriate or ambiguous.

F. Weighting Procedures

Table II-4 displays the proportions of the population of 126,703 who fell into each use stratum for the initial four utilization variables.

TABLE II-4
Use Levels for Medicaid Evaluation Population

Variable	User Group	Frequency of Use	Population (N=126,703)	Percent of Population
1. Doctor Visits	None	0	23,759	18.8%
	Medium	1-15	96,811	76.4%
	High	16+	6,133	4.8%
2. Prescriptions	None	0	30,130	23.8%
	Medium	1-41	90,741	71.6%
	High	42+	5,832	4.6%
3. Laboratory Tests	None	0	74,786	59.0%
	Medium	1-17	44,590	35.2%
	High	18+	7,327	5.8%
4. Emergency Room	None	0	100,467	79.3%
	Medium	1-2	23,650	18.6%
	High	3+	2,586	2.1%

For each of these variables, the estimate of net reduction attributable to PPSP was multiplied by the appropriate population percentage to derive estimates of PPSP impact on the total population. For example, for the total sample the net reduction in payments for non users of doctor visits was multiplied by .188 (18.8%), for medium users by .764 and for high users by .048. Thus, following the earlier example, the average reduction in doctor visits for the total population would be: $(-.11 \times .88) (-.71 \times .764) (-6.77 \times .48) = -.888$ doctor visits per recipient.

For variables for which population proportions were not available (e.g., total payments, inpatient hospitalization, total ambulatory payments, x-rays) estimates were weighted according to the doctor baseline visit proportions. Thus, someone who had no doctor visits in the baseline period (i.e. a non user) could have utilized other services and thus incurred costs. As a result, average baseline total payments, inpatient hospital, ambulatory services and x-rays, all had averages greater than zero for non users. Doctor visits was selected as the weighting variable for several reasons:

1. The doctor visit is the point of entry to the health care system for the majority of recipients and, as such, is the key variable in determining overall rates of utilization.
2. The choice to go to the doctor is the area of greatest client option. Once the contact is made, most other utilization must be initiated by the physician.
3. The number of doctor visits is the variable with most direct program implications. It is the variable most likely to be used to differentiate clients and upon which to base decisions on program targeting and potential impact.

4. Alternative stratification variables (prescriptions and laboratory tests) were tried in order to test the sensitivity of the results to the choice of weighting variables. While there were differences in the magnitude of the effects noted for each level of utilization (stratum) the direction of effect remained constant across all stratifications. Further, the average effect per 1,000 recipients, weighted by doctor visits fell at the mean of the average effects for all weighting schemes tested.

III. FINDINGS

The evaluation of PPSP focused directly on changes in patterns of utilization and cost of health care services, and on the client's satisfaction with care and perceptions of access to and quality of care received. In addition, an assessment of the equivalence of care provided under the sponsored (PPSP) and conventional (PPSP) systems is being prepared.

A. Utilization and Cost of Health Care Services

The underlying hypothesis of PPSP was that reduced client choice would lead to reductions in the use and cost of medicaid services utilized. To test that hypothesis, the average use and cost of Medicaid services during the baseline period was compared to comparable figures from the experimental period. If the hypothesis was to be confirmed, significant reductions in use and cost of services by PPSP enrollees should be found.

The analysis of utilization and cost is organized around four key variables: Doctor Visits, Total Ambulatory Services, In-patient Hospitalization and Total Title XIX Payments. Doctor visits are included as a discrete variable for several reasons. First, the baseline number of doctor visits is the principal stratifying variable, and thus the key descriptor of non, medium and high utilizing recipients. Second, the number of doctor visits is viewed as the most important indicator of utilization, since it represents the point of entry to the health care system for most clients, and thus is the point

of which recipients exercise greatest freedom of choice and control over health care utilization.

Ambulatory services include doctor's office visits and non-emergency outpatient visits, and are thus partially duplicative of the doctor visit variable. In addition to doctor visits, laboratory tests, x-rays, prescriptions, emergency room visits and all other medical services not provided in an inpatient hospital setting are included in this variable. Some services which do not require sponsor approval, such as dental, chiropractic and podiatric services, are thus included in the ambulatory service category even though they are not directly affected by PPSP.

It is felt that the inclusion of such services does not harm the analysis, since they represent an extremely small percentage of total payments. Further, including them allows us to perfectly partition total expenditure between ambulatory and inpatient hospital services.

The analysis of utilization and cost is further divided into separate discussions of findings for all clients, AFDC clients, AFDC recipients age 22 and over, AFDC age 15 to 21, AFDC age 14 and under and SSI recipients.

1. All Cases

The first stage of the analysis looked at the impact of PPSP on all enrollees versus the entire control group. Detailed

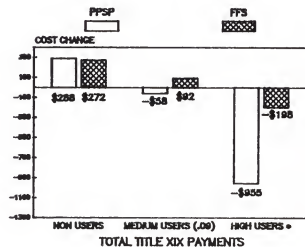
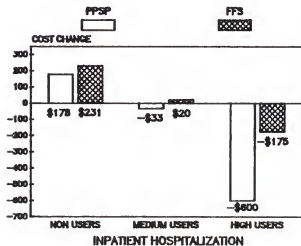
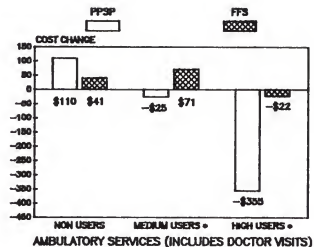
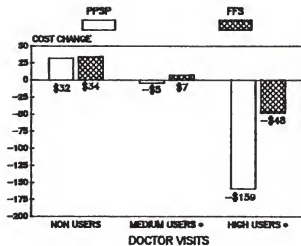
reports of the data are contained in Tables ALL-1 through ALL-8 in Appendix D. A summary of the findings are as follows:

- o Doctor Visits - The doctor visit variable is the sum of physician office and non-emergency hospital outpatient visits and includes only charges for physicians' services. Other medical activities which might have occurred during or as a direct result of a doctor visit, such as laboratory tests, x-rays and prescriptions were assessed separately.

As indicated in Chart III-1 for non users in both the PPSP and FFS groups, there were increases in both the number and cost of doctor visits with no statistically significant difference between the two groups. For the medium user group (1 to 15 visits in the baseline) PPSP enrollees had an 11.4% reduction (.62 visits) in number of visits and a 5.3% decline (\$4.83) in payments. For the FFS group the changes were a 1.6% (.09 visits) increase in visits and a 7.2% (\$6.98) increase in payments. The differences for both visits and payments were statistically significant. The net savings was approximately \$12. The reductions and savings for the high users were substantially greater. The PPSP group showed a 36.6% (9.38 visits) decline in the number of visits and a 40.4% (\$158.89) reduction in cost, compared to

CHART III-1

PPSP EFFECTS : ALL CASES



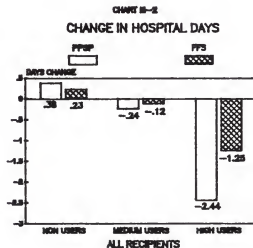
a reduction of 9.6% (2.61) in visits and 11.4% (\$47.97) in payments for those recipients in traditional FFS. Net savings were \$111.

For non- users there was a net increase in expenditures for ambulatory care of approximately \$69 for the PPSP group compared to the control, as shown in Chart III-1. Of the component services which comprise ambulatory care, doctor visits, laboratory tests and emergency room visits all showed slight net decreases, while small increases were found for prescriptions and x-rays.

Among medium users there was a statistically significant net reduction of \$96 with substantial decreases in the number and cost of doctor visits (-.71), prescriptions (-1.18) and laboratory tests (-2.04). No significant changes were found for x-rays or emergency room use. The lack of significant reduction in emergency room visits was found in all groups studied and may be attributed to a Medicaid policy which disallows payment for an emergency room visit without a documented medical emergency.

The net savings in payments for high users was \$333 (Chart III-1). Net reductions among component services were 6.77 doctor visits, 9.61 prescriptions, 10.63 laboratory tests and 1.27 x-rays. All differences were statistically significant at the .05 level.

- o Inpatient Hospitalization - The payment figures reported are the sum of institutional and professional charges incurred during inpatient hospital stays. In addition, changes in the number of stays and number of IPH days were reviewed. There was a slight net increase in the number of hospital days among non users, a corresponding slight net decrease among medium users and a substantial, but not statistically significant, net reductions for high users. (Chart III-2).



As indicated in Chart III-1, payments for hospitalization followed the same pattern, with a slight (\$53) increase

among non users and decreases of \$53 and \$425 for the medium and high users respectively.

- o Total Title XIX Payments - As indicated by Chart III-1, changes in total payments followed a pattern consistent with the findings reported earlier. There was a \$16 net increase in payments for the non user group, with decreases of \$150 in total yearly payments for medium users and \$757 for recipients who had been high users during the baseline period. The net reduction for the high users is significant at the .05 level, while for the medium users the level of significance was .09. The net change for the medium user group was further tested employing nonparametric procedures, which are less sensitive to the extreme variability of the data and to distributional characteristics of the sample. Both the medians test and the Kruskal-Wallis ranks test indicate that the net reduction in total payments for medium users is significant at the .002 level. These results, coupled with a statistically significant reduction in the total number of billings and the consistent reductions found in component services, lead us to conclude that there was a true reduction in payments for medium users.

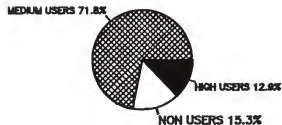
2. Utilization and Cost of Health Care Services - Subgroups
There was considerable basis to believe that the impact of PPSP would be substantially different for subgroups of the population, as defined by eligibility group

(AFDC/SSI) and age. Capitation fees for HMO's and CAPS are scaled according to the age, sex and eligibility of recipients, based on consistent differences in the level and pattern of utilization of the different groups. Also, adults are the initiators of contact with the health care system, and are hence more likely to be influenced by a system which restricts choice. Finally, SSI recipients have a documented medical need, and, in the case of these clients with chronic medical problems, are much more likely to have well established patterns of use and provider relationships. Thus, they are less subject to modification of utilization patterns. Accordingly, separate analyses were done for the AFDC only, AFDC age 0-14, AFDC age 15-21, AFDC age 22+ and SSI only subgroups. Initial evidence of the differences between those groups is provided in Chart III-3. The data clearly indicate that high users of medical services are concentrated among the AFDC adult (age-22+) and SSI groups, with AFDC adults almost seven times (21.5%, vs. 3.2%) as likely to be high users as children, and almost three times as likely as AFDC recipients age 15-21 (21.5% vs. 7.3%). Further, AFDC children are much more likely (21.4%) to be non-users than either AFDC adults (8.6%) or SSI recipients (14.2%).

- a. AFDC Only - Chart III-4 summarizes the impact of PPSP on payments for health care services used by AFDC recipients. (Detailed results are contained in Tables AFDC-1 through AFDC-8 in Appendix D).

CHART III-3

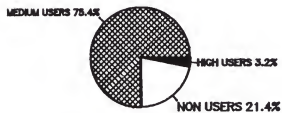
DISTRIBUTION OF DOCTOR VISITS BY SUBGROUP



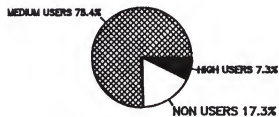
TOTAL SAMPLE



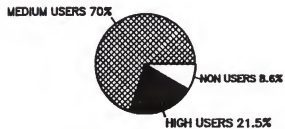
ALL ADC



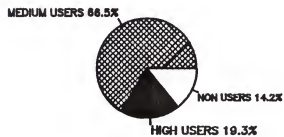
ADC AGE 0-14



ADC AGE 15-21



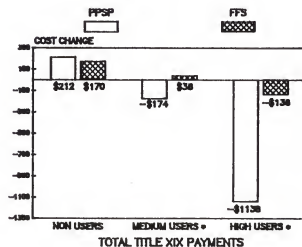
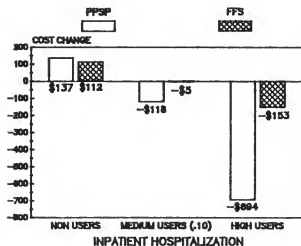
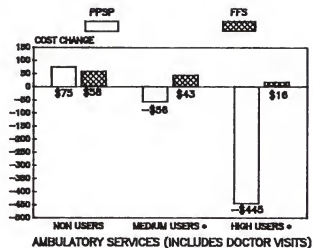
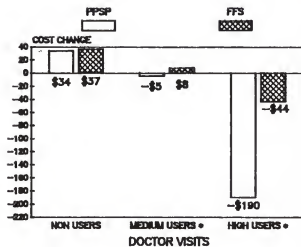
ADC AGE 22+



ALL SSI

CHART III-4

PPSP EFFECTS : ADC RECIPIENTS



- o Doctor Visits - As was true for the total sample, there were significant net reductions in the number and cost of doctor visits for medium and high users. Among the medium user group, the net changes were very comparable to the total sample, with results of -.78 visits and -\$12.49. For high users, the reductions were markedly greater, with a net decrease of 8.3 doctor visits and a corresponding savings of \$145.99.
- o Ambulatory Services - The most notable difference between the AFDC sample and the total sample is among high users, with a net savings of \$460 vs. \$333 for all cases. The greatest differences in component services is found in the number and cost of prescriptions, with PPSP enrollees having a net decrease of 24.14 prescriptions with an associated savings of \$178.51.
- o Inpatient Hospitalization - There are no substantial differences in the effect of PPSP on hospitalization between the AFDC sample and the total sample. For non-users there was a net increase of \$25 in payments for hospitalization, while for medium and high users, there were net reductions of \$113 and \$541. The net reduction for medium users was significant at the .10 level.
- o Total Title XIX Payments - The net savings attributable to PPSP for medium and high users are substantially higher for the AFDC group than for the total sample.

Among medium users, the reduction in payments was \$212 and for high users the yearly cost reduction was \$1,000. Both figures are approximately one-third greater than those found for the total sample.

b. AFDC Recipients: Age 22+ (Detailed findings in Tables AFDC 3-1 through AFDC 3-8 in Appendix D)

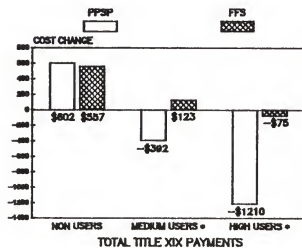
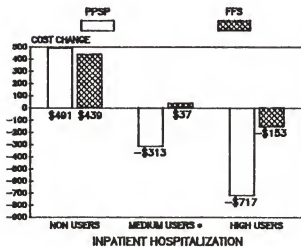
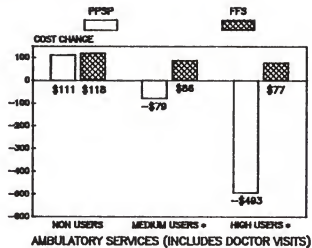
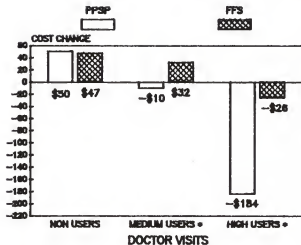
There are statistically significant reductions in number of services and payments for all variables evaluated for medium and high user groups. For all variables except payments for ambulatory services, the net reductions were greater for the AFDC age 22+ group than for any group studied.

- o Doctor Visits - Among non users, both the PPSP and FFS groups showed increases in number and cost of doctor visits, with the PPSP enrollees having 1.88 visits in the experimental period, compared to 2.32 visits for the traditional FFS sample. For medium users, the PPSP enrollees had a decline of 1.06 visits, while the FFS group had an increase of .90 visits. Thus, the net reduction for the PPSP group was 1.96 visits with an associated savings of \$14.95. The high user group showed net decreases of 9.95 visits and \$157.98. For medium users, the reductions are double those for the total sample, while the high user figures are 1.5 times those for the total sample.

- o Ambulatory Services - Again, the reductions for the AFDC

CHART III-5

PPSP EFFECTS : ADC RECIPIENTS AGE 22+

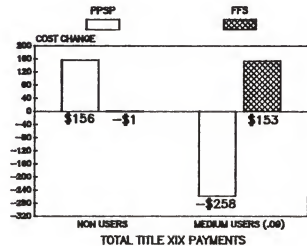
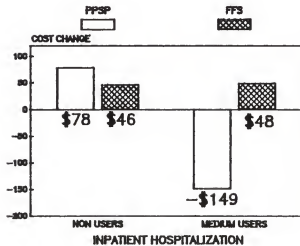
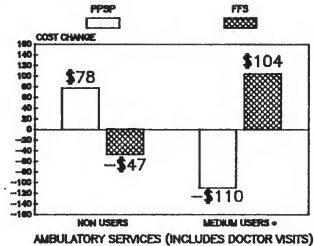
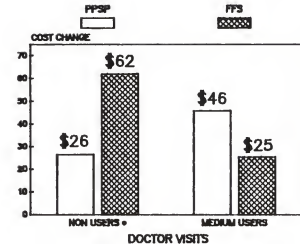


age 22+ group were substantially higher than for the total sample. As indicated in Chart III-5, the net savings in ambulatory service payments were \$165 for medium users and \$570 for the high user group. It is particularly significant that the FFS group showed increases in ambulatory service payments among medium and high users, while PPSP enrollees had substantial decreases among both groups.

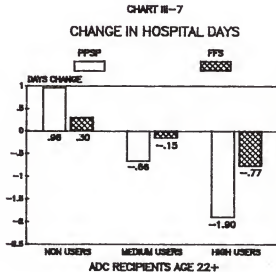
- o Component services of ambulatory care also demonstrate the strong impact of PPSP on this group. The net reduction in prescriptions among medium users was 2.67 compared to 1.18 for the total sample. For laboratory tests the comparable decreases are 2.67 tests (age22+) and 1.18 (total). Among the high users, prescriptions had a net decrease of 25.27 (9.61 total sample) and laboratory tests showed a net reduction of 5.92 (2.04 total sample).
- o Inpatient Hospitalization - The AFDC age 22+ group was the only group which had a statistically significant net reduction in inpatient hospital payments. For medium users, the savings were \$350, significant at the .05 level. For high users, the reduction was \$564. Among all medium users studied, the inpatient hospital savings were seven times greater for the AFDC 22+ group than for the total sample. As indicated in Table III-7,

CHART III-6

PPSP EFFECTS : ADC RECIPIENTS AGE 15-21



there was a reduction of .51 days of hospitalization for medium users (significant at the .07 level), while for high users the net reduction was 1.13 days).



- o Total Title XIX Payments - As would be expected, savings in total payments are substantially higher for AFDC adults than for any other subgroup or for the total sample. Among medium users, the net savings were \$515 per recipient per year, and for high users \$1,135 was saved.
- c. AFDC Recipients: Age 15-21 (Detailed results in Tables AFDC 2-1 through AFDC 2-8 in Appendix D) - Results for the AFDC 15-21 age group contained in Chart III-6 are reported only for non users and medium users. There were substantial reductions in payments for high users, but the number of cases

(N less than 20) present in the final sample was too low to have confidence in the validity of the findings.

- o Doctor Visits - For non users, PPSP enrollees were significantly lower in the number (1.13) and cost (\$35.46) of doctor visits although both groups rose. For medium users, both PPSP and FFS groups showed slight increases, but the net difference was not statistically significant.
- o Ambulatory Services - The age 15-21 age group of AFDC recipients showed a substantial net increase in payments for ambulatory services among baseline non users, with an increase of \$78 for PPSP enrollees and a decrease of \$47 for clients in traditional FFS. Among medium users, there was a statistically significant net reduction of \$224. It is not clear what the source of the savings was, since component services show either insignificant net increases and very small net decreases among medium users. This result should be viewed with caution until further research into the sources of the reduction can be conducted. Nonetheless, the direction of net change for both non-users and medium users is consistent with the hypothesized effects of PPSP, suggesting that prior non-users experienced some increase in health care, while medium users decreased relative to recipients in traditional FFS. For medium users the net decrease

in payments was approximately double that for the entire sample and 37% higher than the savings reported for all AFDC recipients.

- o Inpatient Hospitalization - Savings in payments for hospitalization were greater for the 15-21 group than for the entire AFDC sample or for the total sample. The data in Table III-5 indicates a net cost reduction of \$197 for medium users in the PPSP enrolled group. This net reduction is almost four times greater than for the total sample and almost double the net reduction among all AFDC recipients. The reduction was not statistically significant.
- o Total Title XIX Payments - Among non users, there was a net cost increase of \$157 which was not statistically significant. For medium users, the net cost reduction was \$411, which was significant at the .09 level.

- d. AFDC Recipients: Age 0-14 (Detailed results in Tables AFDC1-1 through AFDC 1-8 in Appendix D). All net change figures are dramatically lower for AFDC children than for either the total sample or for the entire AFDC sample. The only statistically significant findings indicate slight net increase in utilization and cost for the PPSP enrolled group in prescriptions, x-rays and inpatient hospitalization. Among non-users and medium users, there were small net increases in Total Title XIX Payments for PPSP enrolled recipients.

Thus, PPSP clearly did not impair access to care for AFDC children, and may have resulted in a slight increase in services received. To put these findings in context, it should be remembered that for all use strata, Total Title XIX Payments for children in the baseline period were only about one third of average payments for the total sample.

- e. SSI Recipients - As was the case for the AFDC age 0-14 group, the impact of PPSP on SSI recipients was noticeably less than for the total sample and for the total AFDC sample. The findings for the SSI group are statistically significant only for prescriptions among medium users, and the pattern of reductions/costs was almost random. It should be remembered that recipients in this group have passed a stringent screening process to document the existence of a chronic medical problem. Additionally, this group is most likely to have a well established physician relationship and pattern of continuing care. In light of these considerations, it is not surprising that the observed changes were small, despite the high utilization pattern of the SSI group.

B. Access and Satisfaction with Medical Services

PPSP was intended not only to limit the utilization and cost of health care services, but to improve access to mainstream care and to improve the overall management of medical care. One means to assess the impact of PPSP on these latter goals is the client

satisfaction survey, which provides a means to tap client perceptions about the medical care they receive. The survey instrument "Your Feelings About Medical Care" (Exhibit B in Appendix E) and a cover letter (Exhibit A, Appendix E) were sent to a randomly selected subsample of 5,000 PPSP recipients (out of 10,271) and 5,000 FFS recipients (out of 9,981). For those clients who failed to respond, a reminder notice and duplicate questionnaire was sent. Final response rates for the baseline questionnaire were 55% for PPSP clients and 56.6% for FFS clients. An analysis of non-respondents done by Dr. Harry Harry Perlman of Michigan State University indicated that there were no meaningful differences between respondents and non-respondents in terms of demographic characteristics and utilization.

The experimental period questionnaire was mailed in the spring of 1985 to clients who had responded to the baseline survey. Two different forms were used, one for PPSP clients (Exhibit C Appendix E) and another for FFS recipients (Exhibit D Appendix E). Two forms were used in order to incorporate questions unique to the PPSP experience for the appropriate clients. After reminder notices, response rates were 51.9% for PPSP recipients and 55.1% for FFS clients. Final samples (i.e., those who responded to both surveys) were 1,428 PPSP clients (28.6% of the original 5,000) and 1,560 FFS recipients (31.2%). (Detailed results are contained in Appendix E).

1. Access to Care - The results from the access to care dimension of the survey are divided into five categories:

arrangements for doctor visits, the actual visit, emergency situations, referrals to specialists and second opinions.

- a. Doctor Visit Arrangements - Table III-1 displays the results from three questions relating to the convenience and ease with which recipients make arrangements to see a physician.

The data indicates that there were no large differences between the two groups in any dimension, with very little change between the baseline and experimental periods. The only questions which showed any variation between the groups was the wait for an appointment, where PPSP users were less likely to report an extended (more than two weeks) wait for an appointment in the experimental period.

- b. The Doctor Visit - Survey results for questions referring to the actual doctor visit are reported in Table II-2. Again, the results indicate no essential difference between the PPSP and FFS groups, and no meaningful shifts from baseline to experimental period for either group of respondents.
- c. Emergency Situations - The data relating to what clients did if they needed care after office hours indicates that, in the baseline period, approximately 50% of both groups

TABLE III-1
Doctor Visit Arrangements

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1. 2 days or less	64.5	59.2	64.3	63.2
	2. 3 days to 2 weeks	30.1	25.2	30.2	29.8
	3. More than 2 weeks	5.4	15.6	5.5	7.1
How long does it take you to get to the place where you usually go for medical care?	1. Less than 15 minutes	36.4	36.2	36.1	37.5
	2. 15-30 minutes	47.4	49.6	47.9	47.4
	3. 31-60 minutes	11.7	9.5	12.3	11.3
	4. More than 60 minutes	4.5	4.7	3.8	3.8
How long do you usually have to wait to see the doctor once you get there?	1. 30 minutes or less	54.5	56.0	51.2	53.8
	2. 31-60 minutes	30.2	30.7	33.6	32.0
	3. More than 1 hour	15.4	13.3	15.2	14.0

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

went to the emergency room, while in the experimental period 39% of the FFS reported the emergency room as their principal option, while 51% of the PPSP group indicated ER visits. This data is inconsistent with the utilization data reported earlier, which indicated no difference between the two groups in ER use. Given the low rates of ER use in general, and the fact that virtually all respondents answered this question on the survey, it is probable that most were basing their answer on speculation or past behavior rather than on real experiences in the baseline period.

- d. Referrals to Specialists - This dimension was surveyed only in the experimental questionnaire. Results indicate that PPSP enrollees were slightly more likely to have seen a specialist in the preceding twelve months (41.1% vs. 37.5%) while only 2.7% of the PPSP group indicated that they requested a referral to a specialist but were unable to obtain one from their primary care (sponsor) physician. These figures are lower than those obtained in the Monitoring Project survey and reported in Chapter I. The difference may be attributable to sampling, wording of the question or method of aggregation.
- e. Second Opinion - Again, the question was asked only on the experimental period questionnaire. Of those responding, 22.2% of the FFS group and 22.4% of the PPSP group indicated that they had received a second opinion

TABLE III-2
Doctor Visit

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
When was the last time you got medical care?	1. 0-3 months ago	73.8	67.9	69.7	68.8
	2. 4-6 months ago	14.5	15.2	16.8	15.6
	3. 7-9 months ago	3.8	4.8	5.5	5.2
	4. 10-12 months ago	3.0	5.5	3.4	3.8
	5. More than 12 months ago	4.9	6.6	4.6	6.5
Is there one doctor in particular you usually see at the place you go for medical care?	1. Yes	80.3	78.2	80.5	81.3
	2. No	19.7	21.8	19.5	18.7
During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you didn't like how you are treated?	1. No never,	80.6	83.4	78.9	82.1
	2. Yes, one time	10.7	16.5	12.0	17.8
	3. Yes, more than once	8.7	0.1	9.1	0.1
During the past year, has a doctor or staff person ever been rude to you or to your family?	1. Yes, both doctor & staff	3.4	2.6	3.6	2.6
	2. Yes, only a doctor	2.9	3.2	3.3	4.3
	3. Yes, only a staff person	8.2	7.6	9.1	7.5
	4. No, never	85.5	86.5	84.1	85.7
In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?	1. Excellent	36.9	35.4	36.2	36.0
	2. Good	46.7	47.1	47.5	46.3
	3. Fair	14.8	15.4	15.0	14.6
	4. Poor	1.7	2.2	1.3	3.0

in the preceding year. 3.5% of the PPSP group responded that they had requested a second opinion and could not yet get a referral. As with the results for specialist referrals, these results are lower than those indicated by the Monitoring Project survey.

The data indicate that there were no major differences between the PPSP and FFS in terms of perceptions of access to care. To the extent that client perceptions are an accurate indicator, PPSP seems to have had minimal positive or negative impact on recipients' ability to receive the care they felt they needed.

2. Satisfaction with Care - Table III-3 displays the net change in satisfaction on the nine major dimensions. The scores indicate the net decrease or increase in satisfaction for PPSP respondents compared to those clients who remained in traditional fee-for-service.

For all respondents, only the change in clients' perceptions of the technical quality of care was statistically significant. On no dimension was the net change of sufficient magnitude to have substantive meaning. The maximum net change was +.200, which represents only a four percent net shift on the 5-point scale over which these dimensions were measured.

When the net change results were broken out according to the

TABLE III-3
NET CHANGE IN SATISFACTION

	All Cases	Non Users	Medium Users	High Users

General Satisfaction with Medical Care	.009	-.165	-.002	.088
Accessibility, Convenience	.002	-.164	.007	.053
Art of Care	-.004	-.066	.001	-.044
Technical Quality of Care	-.089*	-.217*	-.100*	-.291*
Efficacy, Outcomes	.200	-.133	-.043	-.068
Total of Art and Technical Aspects	-.061	-.145	-.060	-.203
Physical Environment	-.027	-.064	-.049	-.120
Availability, Resources	-.049	-.080	-.038	-.100
Satisfaction Total	-.042	-.135	-.043	-.031

* Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

respondents' baseline utilization level, the results were somewhat surprising. It had been speculated that high users would be much more likely to show net decreases in satisfaction, since they were the group most impacted by the PPSP program. The results displayed in Table III-3 do not bear out that speculation. The results for high users do not show substantially greater shifts than for the non-user and medium user groups, and no shift is of sufficient magnitude to have any clear implication of a meaningful change in client satisfaction levels.

3. PPSP Specific Questions - A final aspect of the client survey was a series of questions on the experimental questionnaire which were directed at PPSP enrollees and were included to measure the quality of information which those clients had prior to choosing a sponsor and their general experience under the program. The results are presented in Table III-4 for all PPSP respondents and are broken out by utilization level in Appendix E.

Several of the findings are of interest. First, the responses to question A on how clients chose a physician indicate a substantial number of clients (18%) for whom DSS chose a physician. This figure may actually be an understatement, since other data indicates that as much as 30% of the PPSP sample may have been assigned to physicians, and another 25-30% matched to physicians who the client had seen previously.

Second, of all clients responding, 81.9% indicate they are still assigned to the physician with whom they initially enrolled. This finding is consistent with results obtained by the Monitoring Project, and suggests that clients maintained stable physician relationships and did not engage in "sponsor shopping". When clients did change physicians, the most commonly cited reasons were convenience of location and "other".

Third, the responses to Questions D and E indicate that the department's efforts to inform clients were not totally successful. Over 30% of respondents replied that they either did not have enough information or they were not sure. That the department's information effort was not entirely successful is borne out by the fact that over 38% of clients responding thought they would lose Medicaid benefits if they failed to enroll in PPSP.

Finally, clients are not entirely satisfied with the sponsor plan (48.1% are satisfied), and only 32.7% indicate a definite preference to stay in the program while 51.5% would prefer traditional FFS. These results are not surprising, since PPSP represented a considerable restriction in client's freedom of choice.

C. Conclusions

The findings indicate that PPSP was successful in reducing

utilization and cost of health care services for AFDC recipients age 15 and over. For AFDC clients under 15 there were small, nonsignificant net increases, while for Blind and Disabled (Non-Medicare SSI) recipients results were mixed. For all clients included in the study there was a slight increase in total Title XIX payments for non-users, with reductions of \$150 for medium users and \$757 for high users. Among AFDC recipients age 15-21 there was a \$157 net increase in total payments for non-users and a \$411 net reduction for medium users. There were too few high users in the study to make reliable estimates of program impact on this group. The most substantial program impact was found among AFDC recipients age 22 and over. Among non-users there was a net increase of \$45 in total payments. For medium users, the net reduction in payments was \$515 per year per recipient, and for high users a savings of \$1,135 was found.

The results of the Client Satisfaction Survey indicate that PPSP had minimal positive or negative impact on either access to care or client satisfaction with medical services. These results remained consistent when broken out by baseline level of utilization, with no group having shifts in satisfaction of sufficient magnitude to indicate a meaningful change in satisfaction levels.

TABLE III-4
PPSP SPECIFIC QUESTIONS

	Non	Medium	High
A. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?			
1. I decided on my own	44 (51.2%)	305 (59.9%)	62 (71.3%)
2. My doctor asked me to sign up	2 (2.3%)	29 (5.7%)	5 (5.7%)
3. DSS picked a doctor for me	20 (23.3%)	95 (18.7%)	8 (9.2%)
4. DSS helped me decide	10 (11.6%)	23 (4.5%)	6 (6.9%)
5. A relative or friend helped me decide	10 (11.6%)	57 (11.2%)	6 (6.9%)
	86 (100%)	509 (100%)	87 (100%)
B. Are you still signed up with the same doctor?			
1. Yes	69 (80.2%)	418 (81.5%)	78 (85.7%)
2. No	14 (16.3%)	79 (15.4%)	11 (12.1%)
3. Not sure	3 (3.5%)	16 (3.1%)	2 (2.2%)
	86 100%	513 100%	91 100%
C. If you are not with the same doctor, why not?			
1. He is no longer in business	2 (9.5%)	12 (11.9%)	1 (5.6%)
2. I changed to a more convenient location	4 (19.0%)	29 (28.7%)	2 (11.1%)
3. I did not like the doctor	0 0	15 (14.9%)	3 (16.7%)
4. My medical situation changed	6 (28.6%)	12 (11.9%)	3 (16.7%)
5. Other	9 (42.9%)	33 (32.7%)	9 (50.0%)
	21 100%	101 100%	18 100%
D. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a doctor for you and your family?			
1. Yes	55 (66.3%)	333 (67.1%)	69 (76.7%)
2. No	19 (22.9%)	105 (21.2%)	13 (14.4%)
3. Not Sure	9 (10.8%)	58 (11.7%)	8 (8.9%)
	83 100%	496 100%	90 100%

E. What did you think would happen if you didn't sign up quickly?

1. Nothing	10 (21.7%)	62 (22.7%)	10 (21.3%)
2. I would lose Medicaid benefits	19 (41.3%)	106 (38.8%)	15 (31.9%)
3. I would have to go to a new doctor	17 (37.0%)	105 (38.5%)	22 (46.8%)
	46 100%	273 100%	47 100%

F. Are you satisfied with the Medicaid Sponsor Plan?

1. Yes	57 (64.8%)	313 (61.3%)	58 (64.4%)
2. No	17 (19.3%)	119 (23.3%)	20 (22.2%)
3. Not Sure	14 (15.9%)	79 (15.5%)	12 (13.3%)
	88 100%	511 100%	90 100%

G. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?

1. Medicaid Sponsor Plan	24 (27.6%)	171 (33%)	33 (35.9%)
2. Regular Medicaid Card	39 (44.8%)	271 (52.3%)	49 (53.3%)
3. Not Sure	24 (27.6%)	76 (14.7%)	10 (10.9%)

IV. SUMMARY AND DISCUSSION

A. Introduction

This report is one of two reports on the results of a three year federally funded project to test the impact of four alternative means of managing care and reimbursing providers. The four alternatives were:

1. Traditional Fee-for-Service (FFS) - Clients were allowed freedom to choose among Medicaid providers, with all payments made on a fee-for-service basis.
2. Physician Primary Sponsor Plan (PPSP) - Clients enroll with a sponsor physician, who has responsibility for providing or authorizing most medical care for the client. Exceptions include podiatric, chiropractic, vision, hearing, family planning, nurse midwife and dental services. Reimbursement to providers is on a fee-for-service basis, plus a \$3.00 per month case management fee.
3. Health Maintenance Organization (HMO) - Clients sign up with an HMO, which assumes responsibility for all covered care used by the client, except dental services and personal care. Also, clients in Long Term Care and special mental health care are ineligible for HMO enrollment. Reimbursement is on a capitated basis, in which the HMO is a monthly premium based on the age, sex and eligibility status of the client, and is at risk for all costs incurred.
4. Capitated Ambulatory Plan (CAP) - This similar to the HMO, except that providers are not at risk for costs of inpatient

TABLE IV-1

TOTAL TITLE XIX COST REDUCTION PER 1,000 RECIPIENTS
(ALL RECIPIENTS)

LEVEL OF DOCTOR VISITS	AVERAGE REDUCTION		NUMBER OF RECIPIENTS/1000	REDUCTION/1,000	
1. NONE	\$15.94	1	188	\$2996.72	
2. OTHER (1-15)	(\$149.06)	2	764	(\$113881.84)	
3. HIGH (16+)	(\$757.69)		48	(\$36369.12)	
			-----	-----	
			1000	(\$147254.24)	3

1 The cost increase of \$15.94 is not statistically significant

2 Significant at the .09 level

3 This figure represents the net reduction in payments to providers for services to recipients and does not include case management fees or administrative costs of running the PPSP program.

hospitalization. Reimbursement for ambulatory services is on a capitated basis, with payments for inpatient hospitalization made to the hospital on a fee-for service basis.

The current report assesses only the traditional FFS and PPSP alternatives. Reports documenting evaluations of HMO and CAP, as well as a comparison of all four alternatives, will be forthcoming.

B. Summary of Major Findings

1. All Recipients - PPSP resulted in significant net reductions in cost for medium and high users, with a small net increase for non-users. Table IV-1 displays annual savings per 1,000 enrolled recipients, based on a population distribution of 188 non-users of doctor visits per 1,000 recipients, 764 medium users and 48 high users. The projected net reduction in payments to providers for services is \$147,254 or approximately \$147 per recipient per year. Note that this figure is a gross savings estimate and does not include case management fees or administrative costs. Case management fees are fixed at \$3.00 per month (\$36.00 per year) and administrative costs are estimated to be approximately \$7.00 per enrolled recipient per year. Thus, the net savings attributable to PPSP are approximately \$104,000 per 1,000 enrolled recipients per year. Exact estimates of administrative costs and the methodology used to derive them is in Appendix F.

2. Subgroups - The PPSP program did not result in significant net cost reductions for SSI clients. Table IV-2 indicates that, for all AFDC recipients, the net reduction in payments for services was \$197,820 per 1,000 enrolled recipients, with net program savings of approximately \$155,000 per year per 1,000 enrollees.

Further analysis revealed that no significant net reductions in payments accrued for AFDC recipients age 0-14. Tables IV-3 and IV-4 display estimated annual net reductions in payments for AFDC recipients age 15-21 and 22+, respectively. The results indicate PPSP resulted in a reduction in payments of \$284,544 for the 15-21 group and \$506,208 for recipients age 22 and over. Note that the estimate for the 15-21 group does not include a reduction for high users, since there were too few cases upon which to base an estimate. Savings after administrative costs are deducted are approximately \$241,000 per 1,000 enrollees age 15-21 and \$463,000 per 1,000 clients age 22 and over.

3. Satisfaction and Access - The results indicate that PPSP had minimal impact on access to and satisfaction with care. The data demonstrate that both PPSP and FFS were quite satisfied with the care received and access to services in the baseline period. No significant shifts in either satisfaction or perception of access were found in the experimental results.

TABLE IV-2

TOTAL TITLE XIX COST REDUCTION PER 1,000 RECIPIENTS
(AFDC RECIPIENTS)

LEVEL OF DOCTOR VISITS	AVERAGE REDUCTION	NUMBER OF RECIPIENTS/1000	REDUCTION/1,000	
		1		
1. NONE	\$41.30	189	\$7805.70	
2. OTHER (1-15)	(\$212.67)	769	(\$163543.23)	
3. HIGH (16+)	(\$1001.98)	42	(\$42083.16)	
		----- 1000	----- (\$197820.69)	2

1 The cost increase of \$41.30 is not statistically significant

2 This figure represents the net reduction in payments to providers for services to recipients and does not include case management fees or administrative costs of running the PPSP program.

TABLE IV-3

TOTAL TITLE XIX COST REDUCTION PER 1,000 RECIPIENTS
(AFDC RECIPIENTS AGE 15-21)

	AVERAGE REDUCTION		NUMBER OF RECIPIENTS/1000	REDUCTION/1,000	
LEVEL OF DOCTOR VISITS					
1. NONE	\$157.29	1	204	\$32087.16	
2. OTHER (1-15)	(\$411.21)	2	770	(\$316631.70)	
3. HIGH (16+)	\$0.00	3	26	\$0.00	
			-----	-----	
			1000	(\$284544.54)	4

1 The cost increase of \$157.29 is not statistically significant

2 Significant at the .09 Level

3 No estimate made for this group. Insufficient number of cases.

4 This figure represents the net reduction in payments to providers for services to recipients and does not include case management fees or administrative costs of running the PPSP program.

TABLE IV-4

TOTAL TITLE XIX COST REDUCTION PER 1,000 RECIPIENTS
(AFDC RECIPIENTS AGE 22+)

LEVEL OF DOCTOR VISITS	AVERAGE REDUCTION	NUMBER OF RECIPIENTS/1000	REDUCTION/1,000
1. NONE	\$45.50	113	\$5141.50
2. OTHER (1-15)	(\$515.80)	800	(\$412640.00)
3. HIGH (16+)	(\$1134.60)	87	(\$98710.20)
		<u>1000</u>	<u>(\$506208.70)</u>

1 The cost increase of \$157.29 is not statistically significant

2 This figure represents the net reduction in payments to providers for services to recipients and does not include case management fees or administrative costs of running the PPSP program.

C. Other Considerations

1. Mandatory versus Voluntary - PPSP was designed and implemented as a mandatory program, wherein all Medicaid clients, with very limited exceptions, would be required to choose among the three managed care options (PPSP, HMO, CAP) and traditional FFS would be phased out. In reality, this choice was never enforced to its intended degree. Clients who were unable or unwilling to choose were not forced to do so, except in the case of those recipients identified as part of the PPSP sample. PPSP sample recipients who failed to respond to the enrollment letter, or who chose a physician who was not under contract as a sponsor, were either computer matched to a sponsor physician whom they had seen previously, or, failing that, were blindly assigned to a sponsor physician with an office within the client's zip code. These procedures were applied only to the study group, and were never implemented for the general Medicaid population. Thus, a confounding factor was introduced into the study. If clients were assigned to unfamiliar physicians, or had an established physician relationship disrupted by the assignment, there may have been a negative effect on the likelihood of utilization. Further, there may have been some bias introduced by client self-selection. For example, if recipients who were assigned were either those with the weakest connection to the health care system, or conversely, were those with patterns of excessive utilization, this group may not be representative of the general Medicaid

population. If a mandatory program, which would inevitably require matching and assignment is ultimately implemented, the results obtained will be fully applicable. If the program is not fully mandatory to the extent that method of enrollment partially determines program impact, relationship of study findings and program effect for all enrollees must be viewed with some caution. While we are currently unable to fully identify the effect of enrollment method, preliminary evidence suggests that net program impact was somewhat greater for clients who were computer matched or assigned than for clients who voluntarily enrolled in the program.

A further manifestation of the lack of mandatoriness in PPSP is the high number of PPSP enrollees who returned to unsponsored care after enrollment. Of those clients initially enrolled, almost 21% subsequently returned to the FFS mode of care. It is not entirely clear what effect this high number of dropouts had on the findings. The data suggests that clients returning to FFS tended to be higher users of medical care during the baseline, in which case significant program savings could have been lost for this group of clients. The results also indicate that experimental period costs for clients returning to FFS were higher than those for clients continuously enrolled in PPSP and lower than those for clients in the FFS group. This finding tends to mitigate against the hypothesis that clients reverted

to FFS for the purpose of securing high cost specialty care which they were unable to get under the sponsor program.

2. Case Management - One of the purposes of PPSP was to encourage better management of health care by having a sponsor to coordinate services. By having such a coordinator, it was hoped that unnecessary, duplicative or contraindicated services and procedures would be minimized. This study was unable to directly address this goal. Only by an audit of medical records would it be possible to determine if sponsor physicians were engaged in active management of their patients' health care or were simply functioning as gatekeepers to the health care system.
3. Provider Standards - Part of the initial PPSP proposal was the development of provider standards which were to be used to monitor and control physician behavior. Specifically, physicians whose costs exceeded those for a class group of physicians with similar practices and patient types by a predetermined margin were to be liable for warning, and ultimately removal from the sponsor program. For various reasons, including legal requirements and computer system limitations, these provider standards were never implemented. There are currently plans to implement provider standards as part of the ongoing process of program development. However, development of standards must wait until decisions about the future direction of the sponsor program are finalized. If, for example, it was decided to "target" the program at clients

who exceed a given level of utilization, the current method of calculating standards would be wholly inappropriate.

4. Medicaid Policy Changes - Three changes in Medicaid policy, two of which predate PPSP implementation and one which is now being implemented form an important part of the context in which study results must be viewed. First, prior to the study period, Medicaid implemented a policy which disallowed payments to hospital emergency rooms for nonemergency services. This policy had the effect of substantially reducing emergency room utilization for the entire Medicaid population and explains in great part the lack of significant reductions in emergency room use which can be attributed to PPSP. In effect, the "slack" had already been removed from the system.

Second, at about the same time as clients were being enrolled in PPSP as part of this study, Medicaid announced a program of audits of providers who had exceeded limits for the number of laboratory tests ordered. These physicians were identified based on the number of tests on a patient by patient basis, rather than on the cumulative number of tests ordered. The effect of this program was to cause substantial reduction in the number of tests ordered for high using clients, accompanied by an increase in the average number of tests for clients with no lab tests or a medium number of lab tests. Thus, both PPSP and FFS

groups experienced substantially lower numbers of laboratory procedures among high users and significant increases for other user groups. However, reductions for the PPSP group were comparatively greater and increases relatively lower than for the FFS control group.

The last program change which needs to be considered is the Diagnosis Related Group (DRG) program which is currently being implemented in Michigan. DRG is a program which pays hospitals a fixed amount for a given diagnosis, with the goal of standardizing and reducing the cost of inpatient hospitalization. Obviously, this goal overlaps one of the principal goals of PPSP. Since a large portion of the program savings attributed to PPSP are the result of reduced inpatient hospital payments, caution must be exercised in projecting program savings. To the extent that DRG reduces hospital costs for all Medicaid clients, savings derived from PPSP may be reduced. It should be noted that DRG is anticipated to have little effect on the number of hospitalizations. Further, if PPSP results in shorter lengths of stay, this change will ultimately result in a lowering of the base DRG reimbursement to hospitals. Thus, PPSP and DRG are in many respects complementary programs.

D. Discussion

The results discussed in this report have broad implications for the continuation and potential modification of the PPSP program. One of the principal goals of PPSP was to reduce

or contain the use and cost of Medicaid services. The data indicate that PPSP had mixed success in achieving this objective. There is compelling evidence that enrolling recipients with sponsor physicians resulted in a substantial cost reduction for AFDC recipients age 15 and older. For younger AFDC recipients, there is evidence of slight net increases in the use and cost of Medicaid services, while for SSI recipients there is little evidence of any program impact. Thus, from a strict cost-effectiveness viewpoint, it would seem appropriate to restrict PPSP enrollment to AFDC recipients age 15 and older. To do so would clearly have the effect of maximizing program savings and minimizing administrative costs.

It must be remembered that improving access to mainstream medical care was another major objective of PPSP. The data indicate that this goal may have been achieved for AFDC recipients age 14 and under. For clients who were non-users or medium users in the baseline period, it appears that PPSP resulted in some increase in utilization. Given the extremely low baseline level of use for this group (approximately one-third of that for the general population) this may be a desirable outcome. At a minimum, the results clearly indicate that no impairment of access to care occurred for AFDC children.

Another consideration which mitigates against excluding AFDC children from PPSP is the administrative complexity which would be introduced for clients, providers and the Department

of Social Services. Virtually every AFDC case would be comprised of a mix of recipients required to secure prior approval for medical and those with largely unrestricted choice. Considerable potential for confusion and error would exist under such a system.

With regard to the cost effectiveness of the program, it must be pointed out that PPSP, as currently administered, addresses only client initiated overutilization of Medicaid services. As noted earlier, the initial PPSP design included provisions for establishing provider standards of service and cost, and procedures for progressive sanctions for exceeding those standards. Those standards and sanctions were never implemented and thus, no controls over provider initiated overutilization exist in the current program. Conversely, the program also contains no incentives for physicians who successfully reduce the utilization and cost of medical care for those clients for whom they are a sponsor. Thus, it is probable that considerable potential reductions in utilization and corresponding savings in Medicaid expenditures are being lost. It should be noted that a system of provider standards, sanctions and incentives is currently being studied by a joint group of Medicaid administrators, providers and other interested parties. Decisions about the implementation of such a system will not be possible until a final resolution to the questions of the continuation and potential modification of PPSP are made.

Finally, it should be noted that there is nothing in this

report which addresses the extent to which PPSP succeeded in improving the management of medical care, which was another of the program objectives. An assessment of this issue would necessitate a review of medical records to determine the extent to which sponsor physicians are actively managing and coordinating the care received by recipients for whom they are responsible. Until such a study is undertaken, it cannot be said whether PPSP results in "gatekeeping" versus managing.

- E. Future Research - The findings reported in the study clearly indicate the need for additional research in several areas:
- o Continued monitoring of PPSP enrollees in order to determine if the observed program effects persist over time.
 - o More intensive analysis of program dropouts, particularly those who returned to FFS, to determine the reasons for the change and estimate the effect that clients leaving the program had on net savings/costs. Also, it needs to be determined if some clients left PPSP due to an inability to get necessary care.
 - o Impact of enrollment method should be studied in more detail to determine the relative importance of the PPSP program versus the process by which people were enrolled. This question is important in the

estimation of future program impact under mandatory versus voluntary enrollment.

- o Estimation of PPSP impact statewide. If the sponsor program is to be expanded to cover all clients statewide, research to monitor its effects should be part of the program. Wayne County is unique in several respects, such as the high concentration of providers and clients, relatively low incidence of access problem and high cost of medical care. Thus, the results of this study cannot be extrapolated directly to a statewide program.

APPENDIX A

PHYSICIAN SURVEY: DR. THEODORE GOLDBERG

1. Survey Form
2. Introduction Letter
3. Frequency Tables



WAYNE STATE UNIVERSITY

SCHOOL OF MEDICINE

MAILING ADDRESS:
GORDON H. SCOTT HALL
OF BASIC MEDICAL SCIENCES
540 EAST CANFIELD AVENUE
DETROIT, MICHIGAN 48201

DEPARTMENT OF COMMUNITY MEDICINE

August 13, 1982

Dear Doctor,

The Michigan Medicaid Physician Primary Sponsor Plan (PPSP) recently was implemented on a trial basis in Wayne County. The plan was developed in conjunction with the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians with the stated goal of controlling rising Medicaid costs without adversely affecting the quality of care rendered to Medicaid patients.

In order to assess the effects of this new program, the Department of Community Medicine of the Wayne State University School of Medicine has begun a long term study looking at the economic impact of the PPSP program as well as its impact on providers, recipients and the administrative system of Michigan Medicaid.

In the initial segment of our work, we are sending the attached survey to a sample of all physicians in Wayne County and the affected adjoining areas. The purpose of the survey is to assess the profession's attitudes towards this new program as well as to identify the reasons why physicians are or are not signing up to participate in the program.

The results of the survey will provide detailed objective information regarding the attitudes of physicians which will be important in the evaluation of the program and for any possible future modifications.

Your name has been randomly selected as part of the sample of physicians who are being asked to complete the questionnaire. It is important that we receive the highest response possible to insure that the survey results accurately reflect the opinions of the physician population in a way that is statistically valid. Therefore, your input is extremely valuable.

In a pretest with physicians, it was found that the average time needed to complete the questionnaire was approximately fifteen minutes. We hope you will take the short time required to complete and return the questionnaire in the self-addressed, stamped envelope.

All data will be used for statistical purposes only and no data identifying individuals will be reported. The only reason that your name and address are identified is to enable us to follow up with those who have not yet returned the questionnaire.

Thank you for your assistance and cooperation in this matter.

Yours sincerely,

Theodore Goldberg, Ph.D.
Professor and Chairman

**Survey of Physicians
Regarding the Michigan Medicaid Primary Sponsor Plan**

Please circle the number or letter of your answer and fill in the appropriate information when needed.

I. Personal and Practice Characteristics

1. Age _____ Sex _____
2. Is this your: only office _____ principle office _____
If more than one office are others in: Wayne County _____ Elsewhere _____
3. Are you actively engaged in practice?
(a) Actively practicing full-time (c) Semi-retired
(b) Practicing part-time (d) Retired
4. Are you board certified or eligible in a specialty? (a) yes (b) no
If yes: Specialty _____
5. Do you belong to your local medical society? (a) yes (b) no
6. Primary Activity:
(a) Clinical Medicine (c) Teaching
(b) Research (d) Administration
7. Primary Setting (circle as many as appropriate):
(a) Solo practice (f) Hospital based (not employee)
(b) Partnership (g) Hospital employee
(c) Private group practice (h) Medical school
(d) Pre-paid group practice (i) Public health agency
(e) Industry (j) Other(specify) _____
8. Principle Field of Practice:
(a) Emergency medicine (e) OB/GYN
(b) Family or General Practice (f) Pediatrics
(c) General Surgery or Surgical subspecialty (g) Psychiatry
(d) Internal Medicine (h) Other(specify) _____
9. How long have you been at your present location as a practicing physician?
(a) Less than 2 years (d) 10-20 years
(b) 2-5 years (e) Greater than 20 years
(c) 5-10 years
10. Characterize your patient mix as closely as possible.
(a) Predominantly lower income
(b) Predominantly middle income
(c) Predominantly upper income
(d) Majority lower income with some middle and upper income
(e) Majority middle income with some lower and upper income
(f) Majority upper income with some lower and middle income

II. Medicaid Program (Prior to implementation of Physician Primary Sponsor Plan)

11. Currently, what percentage of your practice is composed of Medicaid Patients?
(a) 0 (d) 26-50
(b) 1-10 (e) 51-75
(c) 11-25 (f) 76-100
12. Are you currently accepting new Medicaid patients? (a) yes (b) no
13. Does the Medicaid population in general utilize services more or less frequently than necessary?
(a) Less frequently
(b) Neither more nor less frequently
(c) More frequently

Respond to questions 14 and 15 regardless of your response to 13.

	strongly disagree	disagree	neutral	agree	strongly agree
14. A major cause of <u>overutilization</u> among Medicaid patients is:					
(a) Use for minor illnesses and complaints	1	2	3	4	5
(b) No cost to recipient	1	2	3	4	5
(c) Use of Emergency Room and inpatient facilities where physician offices would suffice	1	2	3	4	5
(d) Overuse of drugs	1	2	3	4	5
(e) Doctor shopping	1	2	3	4	5
(f) Medicaid administrative policies	1	2	3	4	5

15. A major cause of <u>underutilization</u> among Medicaid patients is:					
(a) Lack of understanding of Medicaid program by Medicaid eligibles	1	2	3	5	5
(b) Inadequate transportation to medical services	1	2	3	4	5
(c) Discomfort with office and clinical settings	1	2	3	4	5
(d) Inability to recognize symptoms requiring professional care	1	2	3	4	5
(e) Distrust of Medical profession	1	2	3	4	5
(f) Medicaid administrative policies	1	2	3	4	5

16. Characterize Medicaid patients in comparison to non-Medicaid patients with respect to the following:

	much lower	lower	no difference	higher	much higher
(a) Overall medical need	1	2	3	4	5
(b) Adherence to physician orders	1	2	3	4	5
(c) Compliance to office routine: (appointment keeping, promptness, etc.)	1	2	3	4	5
(d) Emphasis on preventive medicine	1	2	3	4	5
(e) Maintenance of healthy life styles	1	2	3	4	5
(f) Utilization of drugs	1	2	3	4	5
(g) Utilization of medical services	1	2	3	4	5

17. If you are not currently participating in the Michigan Medicaid Program, rate the following as to their importance in your decision

	did not affect	slightly important	important	very important	extremely important
(a) Physician fees too low	1	2	3	4	5
(b) Too much paperwork	1	2	3	4	5
(c) Long delays in receipt of payment	1	2	3	4	5
(d) Attitude and errors of Medicaid administrative staff	1	2	3	4	5
(e) Low hospital fees	1	2	3	4	5
(f) Characteristics of Medicaid patients	1	2	3	4	5
(g) Do not wish to participate in a government sponsored health care program	1	2	3	4	5
(h) Other (specify) _____	1	2	3	4	5

III. Physician Primary Sponsor Plan (PPSP)

18. How familiar are you with the PPSP?

- (a) Not aware of it
- (b) Aware of it but not much more
- (c) Familiar with its concepts but not specifics
- (d) Familiar with the specifics (have seen the contract)

19. Where have you received most of your information about the PPSP? (Publication in italics)

- (a) County medical society (*e.g. Detroit Medical News* in Wayne County)
- (b) Detroit Medical Society
- (c) Michigan Association of Osteopathic Physicians and Surgeons (*Journal of Michigan Osteopathic Association*)
- (d) Michigan State Medical Society (*Michigan Medicine*)
- (e) Michigan Department of Social Services (*The Bulletin*)
- (f) Public Media
- (g) Other (specify) _____

20. Assess the following aspects of PPSP.

	unfamiliar with provision	strongly dislike	dislike	neutral	like	strongly like
(a) Patient assignment and lock-in	0	1	2	3	4	5
(b) Case management fee	0	1	2	3	4	5
(c) Prior authorization of all referrals by sponsor	0	1	2	3	4	5
(d) MDSS monitoring of physician expenditures and use of services	0	1	2	3	4	5
(e) Twenty-four hour patient coverage	0	1	2	3	4	5
(f) Appeals procedure	0	1	2	3	4	5
(g) Use of 95th percentile criteria for review	0	1	2	3	4	5
(h) Number of medicaid patients per sponsor	0	1	2	3	4	5
(i) Program specification regarding HMOs	0	1	2	3	4	5
(j) Process of peer review	0	1	2	3	4	5
(k) Other (specify) _____	0	1	2	3	4	5

21. How do you anticipate PPSP will affect the following?

	large decrease	decrease	no effect	increase	large increase
(a) Physician reimbursement	1	2	3	4	5
(b) Utilization of health care system by Medicaid patients	1	2	3	4	5
(c) Recipient compliance with physician orders	1	2	3	4	5
(d) Inpatient hospital utilization	1	2	3	4	5
(e) Emergency room utilization	1	2	3	4	5
(f) Doctor shopping	1	2	3	4	5
(g) Drug Utilization	1	2	3	4	5
(h) Patient abuse of Medicaid Program	1	2	3	4	5
(i) Physician abuse of Medicaid Program	1	2	3	4	5
(j) Total cost of Medicaid	1	2	3	4	5
(k) Government involvement in Michigan health care system	1	2	3	4	5
(l) Malpractice insurance costs	1	2	3	4	5
(m) Medicaid case load per physician	1	2	3	4	5
(n) Quality of your relationship with your Medicaid patients	1	2	3	4	5

22. Have you joined or do you intend to join as a Primary Sponsor in the PPSP?

(a) yes (b) no (c) undecided (d) ineligible to participate

23. If yes, was the principle reason to maintain your current Medicaid patient load? (a) yes (b) no

24. How important were each of the following provisions of PPSP in affecting your decision?

	did not effect	slightly important	important	very important	extremely important
(a) Patient assignment and lock-in	1	2	3	4	5
(b) Case management fee	1	2	3	4	5
(c) Prior authorization of all referrals by primary sponsor	1	2	3	4	5
(d) MDSS monitoring of physician expenditures and use of services	1	2	3	4	5
(e) MDSS criteria to expell physicians from plan	1	2	3	4	5
(f) Twenty-four hour patient coverage	1	2	3	4	5
(g) Number of Medicaid patients per sponsor	1	2	3	4	5

IV. Attitudes towards Health Services Delivery

	strongly disagree	disagree	neutral	agree	strongly agree
25. Physicians have responsibility to care for all individuals who lack the ability to pay.	1	2	3	4	5
26. Government has the responsibility to assure that medical care is available to all people who lack the ability to pay.	1	2	3	4	5
27. There should be one class of medicine for all Americans regardless of ability to pay.	1	2	3	4	5
28. Competition is more effective than regulation in controlling health care costs.	1	2	3	4	5
29. Health care for the poor should be provided by voluntary private organizations rather than through governmental programs.	1	2	3	4	5

FREQUENCY TABLES

Physician Survey

Possible Causes of Overutilization by Medicaid Clients

	Strongly Disagree %	Disagree %	Neutral %	Agree %	Strongly Agree %
Use for minor illness or complaints	3	11	16	47	23
No cost to recipients	4	7	8	42	40
Use of Emergency Room and in-patient facilities where physician office would suffice	2	5	14	39	40
Overuse of drugs	5	13	32	34	16
Doctor shopping	2	13	27	35	23
Medicaid administration policies	3	12	43	18	24

TABLE 2

Possible Causes of Underutilization by Medicaid Clients

	Strongly Disagree %	Disagree %	Neutral %	Agree %	Strongly Agree %
Lack of understanding of Medicaid program	12	21	34	7	25
Inadequate transportation	6	19	22	43	11
Discomfort with office and clinical setting	17	46	27	8	3
Inability to recognize symptoms requiring professional care	8	34	24	20	6
Distrust of medical profession	13	42	34	9	2
Medicaid administrative policies	6	18	48	21	7

TABLE 3
Comparison of Medicaid Clients to Non-Medicaid Clients

	Much Lower %	Lower %	No Difference %	Higher %	Much Higher %
Overall medical need	2	3	44	40	11
Adherence to physician orders	9	60	31	1	0
Compliance to office routine (appointment keeping, promptness, etc.)	30	49	19	2	1
Emphasis on preventive medicine	21	32	25	2	1
Maintenance of healthy life styles	26	61	11	1	1
Utilization of drugs	2	16	32	39	11
Utilization of medical services	2	7	30	46	15

TABLE 4
Reason For Not Participating in Medicaid Program

	No Effect %	Slightly Important %	Important %	Very Important %	Extremely Important %
Fee too low	9	6	29	18	38
Too much paper work	6	9	14	14	57
Long delays in payment	9	9	21	32	29
Attitudes and errors of Medicaid admin. staff	9	9	21	18	44
Low hospital fees	9	15	27	21	27
Characteristics of Medicaid patients	14	28	31	24	4
No wish to participate in a government sponsored program	54	18	14	11	4

TABLE 5
Assessment of Major Features of PPSP Program

	Unfamiliar with Provision %	Strongly Dislike %	Dislike %	Neutral %	Like %	Strongly Like %
Patient assignment and lock-in	2	12	13	21	39	13
Case management fee	2	6	20	28	32	12
Prior authorization of referrals	2	12	24	20	30	12
MDSS monitoring of physician expenditures and use of services	2	15	15	41	21	5
Twenty-four hour patient coverage	2	13	24	39	15	7
Appeals procedure	12	21	14	40	10	4
Use of 95th percentile criteria for review	7	18	17	41	13	5
Number of Medicaid patients per sponsor	6	16	19	48	9	2
Program specifications re HMO's	25	23	15	33	2	3
Process of peer review	10	8	13	50	14	5

TABLE 6
Anticipated Effects of PPSP Program

	Large Decrease %	Decrease %	No Effect %	Increase %	Large Increase %
Physician reimbursement	6	34	44	16	0
Utilization of services by Medicaid patients	4	46	38	10	2
Recipient compliance with physician orders	1	5	62	32	0
Inpatient hospital utilization	5	47	45	3	0
Emergency room utilization	14	55	26	5	1
Doctor shopping	32	59	9	1	0
Drug utilization	12	45	43	1	0
Patient abuse of Medicaid program	18	58	21	4	0
Physician abuse of Medicaid program	6	41	49	4	0
Total cost of Medicaid	8	55	25	11	2
Government involvement in Michigan health care system	2	10	29	41	20
Malpractice insurance costs	0	5	68	21	7
Medicaid caseload per physician	4	26	42	25	3
Quality of physician relation- ship with Medicaid patients.	4	8	57	29	2

TABLE 7
Attitudes Toward Health Care Delivery System

	Strongly Disagree %	Disagree %	Neutral %	Agree %	Strongly Agree %
Physicians have responsibility to care for all individuals who lack the ability to pay	14	25	19	28	14
Government has the responsibility to assure that medical care is available to all people who lack the ability to pay	2	6	7	48	37
There should be one class of medicine for all Americans regardless of ability to pay	5	15	13	31	36
Competition is more effective than regulation in controlling health care costs	10	16	22	28	23
Health care for the poor should be provided by voluntary private organizations rather than through governmental programs	24	24	30	14	8

TABLE 8

Reasons for Joining PPSP: Asked Only of Those Indicating
They Had Already Enrolled or Intended to Enroll

	Did Not Affect %	Slightly Important %	Important %	Very Important %	Extremely Important %
Patient assignment and lock-in	30	11	38	11	10
Case management fee	31	23	31	9	6
Prior authorization of referrals	40	23	22	8	7
MDSS monitoring	56	17	21	4	2
MDSS criteria to expel physicians from plan	55	17	15	7	7
Twenty-four hour patient coverage	50	22	18	8	2
Number of Medicaid patients per sponsor	47	20	19	7	6

APPENDIX B

MONITORING PROJECT REPORT

This report was prepared by the Michigan League for Human Services. It summarizes three years of client surveys conducted by the Monitoring Project. It also contains information on the activities of the sponsor specialist office, and other information bearing on the implementation of PPSP and client reactions to the program.

PHYSICIAN PRIMARY SPONSOR PLAN MONITORING PROJECT

A N N U A L R E P O R T

Submitted by:

Michigan League for Human Services

October 1, 1986

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PHYSICIAN PRIMARY SPONSOR PLAN MONITORING PROJECT

SUMMARY

Methodology

Under a contract with the Michigan Department of Social Services, the Michigan League for Human Services has been administering the Physician Primary Sponsor Plan (PPSP) Monitoring Project to assess the pilot project's impact on Medicaid recipients since December 1982. The Monitoring Project has conducted: (1) a monthly survey of randomly-selected recipients enrolled in PPSP; (2) a resurvey of respondents six months later; (3) regular interviews with Medicaid officials and the Sponsor Specialist Office staff; (4) regular review and analysis of telephone calls to the Sponsor Specialist Office; and (5) an ongoing survey of organizations and community groups in contact with the Medicaid population.

Over 1,700 Medicaid recipients (52 percent) responded to surveys regarding their experience under PPSP after being enrolled approximately six to eight weeks. Of the respondents to the initial survey, 56 percent responded to a follow-up survey six months later. These activities are carried out under the oversight of a twelve-member Monitoring and Evaluation Committee which meets regularly to review implementation of PPSP and make recommendations regarding the direction of the Plan.

Findings

Recipient Enrollment in PPSP

Although enrollments have proceeded slower than anticipated under PPSP, over 80,000 Medicaid recipients in Wayne County are enrolled with sponsor physicians. HMO and Clinic Plan enrollment in Wayne County has climbed from about 65,000 to 87,000 since the inception of PPSP. As a result, almost one-half of the eligible Wayne County Medicaid population is now in some type of managed care system.

Client enrollments have shifted from a telephone process through the Sponsor Specialist Office to a paper process involving local DSS offices and sponsor physicians' offices as the point of contact to enroll recipients in the Plan. Although these changes have significantly increased enrollments in PPSP, over 60 percent of survey respondents did not feel adequately informed to choose a health care provider or otherwise were not ready to make a choice at the time they were enrolled.

Relationship with Sponsors

According to the Monitoring Project's monthly surveys, 80 percent of PPSP respondent enrollees continue to see the same provider they used prior to PPSP. Further, the Project resurveys indicate that almost 90 percent of respondent recipients are still with the same physician six months after enrollment despite the PPSP provision that allows them to change physicians. Recipients who were able to select sponsor physicians whom they had already seen for medical care were more satisfied with the plan and experienced fewer access problems than those linked with health providers with whom they did not have an established relationship.

24-Hour Access

Client access to the sponsor physician on a 24-hour basis, which is required in the sponsor contract, is a primary focus of the monitoring effort. Sponsor physicians are required to have their office telephone numbers, which are printed on the restricted MA cards, tied into an answering service during non-business hours; this service must be in contact with the sponsor or an alternate provider.

Consistently, however, the Monitoring Project's surveys show that 45 percent of respondents who tried to contact their sponsors during off-hours but were unable to do so, didn't know where to call, went to the emergency room, or waited until the office opened. In spite of the fact that all such problems are followed up by the Sponsor Specialist Office staff whenever possible, and that testing of sponsors' 24-hour availability is periodically conducted, the Monitoring Project's surveys continue to show a problem in this critical area.

Second Opinions and Specialty Referrals

Enrollees' experiences in obtaining sponsor assistance with referrals to second opinions and specialty care is another focus of the Monitoring Project. The contract requires the sponsor physician to honor any patient-specialist relationship existing at the time of enrollment if he/she makes a specialist referral, and to facilitate a referral if the enrollee requests a second medical opinion.

Data from the Monitoring Project's surveys in the area of sponsor referrals to specialists indicate that 30 percent of respondent enrollees requested such a referral, and almost 1 in 5 were not assisted by their sponsor physicians to access this specialty care. In the matter of referrals for second medical opinions--a service which the sponsor is required to provide under his or her contract--of the 1 in 10 respondent enrollees who requested a second opinion, over 25 percent were not assisted.

Satisfaction Level/Assessment of Care

The satisfaction level with medical care for persons enrolled in PPSP was lower than it was prior to their enrollment in the Plan among survey respondents. Those who were satisfied with care fell from 80 percent before PPSP to about 65 percent after enrollment in PPSP. In the past year, responses to the survey indicate that most recipients feel they are receiving the same level of care under PPSP that they received prior to enrollment in the Plan.

The Project's survey respondents who view the pilot project positively report that PPSP is a good program; they understand the need to prevent unnecessary use of services; they have a good relationship with their doctor; and they generally have no problem. On the other hand, respondents unhappy with PPSP had a wide variety of negative comments which indicate a fear about being "locked in" with a single provider; anxiety about not being able to find a good doctor; concern about the inconvenience of not being able to access doctors of their choice and general difficulties in accessing care; and resentment at being punished because others overuse the health care system.

General Conclusions

1. The Physician Primary Sponsor Plan has proven to be more complex and time consuming to implement than originally anticipated.
2. Effective communication mechanisms with providers, recipients, and DSS workers are essential to minimize problems with the system. Expanded efforts are still needed to better inform all affected parties about the Plan.
3. The role of Sponsor Specialist Office in providing information and resolving problems is critical to protecting recipients rights and their ability to access care in the health system. Staffing problems and busy phone lines have hampered its effectiveness.
4. Medicaid clients who have positive, long standing relationships with physicians who are enrolled as sponsors and have access to reasonable transportation are best able to obtain health care for themselves and their families under the Plan. Persons who do not have one regular doctor or whose physician is not enrolled as a sponsor experience more difficulty with the system.
5. Enrollment methods which have been used to force recipients into the Plan who were unable or unwilling to choose a health provider on their own have not been successful. These methods have caused administrative problems for the Department of Social Services and disrupted access to care for Medicaid recipients. Without a clear need for enrolling Medicaid recipients with low- and moderate-utilization patterns, and absent adequate assurances of access, quality care and effective enrollment methods, mandatory enrollment for the entire Medicaid population appears ill-advised.

INTRODUCTION

Pilot Project Design and Participation

The Physician Primary Sponsor Plan (PPSP) is a Medicaid case management pilot project located in Wayne County*. Under the Plan, categorically eligible Medicaid recipients (AFDC and SSI recipients) are asked to select a sponsor physician (case manager) responsible for providing or authorizing most nonemergency medical services. The sponsor physician receives a \$3 per month case management fee for each enrolled patient in addition to the regular fee-for-service reimbursement. As an alternative to PPSP, Medicaid recipients may choose to enroll with an HMO or Clinic Plan.

Established through the waiver provisions in the Omnibus Budget Reconciliation Act (OBRA) of 1981, the demonstration project presently has over 80,000 Medicaid recipients enrolled with about 1,200 participating physicians, making it one of the largest case management pilots in the country. Approximately 87,000 other recipients are currently enrolled in HMOs or Clinic Plans. Thus, almost half of the eligible Medicaid population in Wayne County (345,325) is in some type of managed care system.

Recipient Enrollment in Managed Care Health Systems (4 Year Comparison)

	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
PPSP Enrollment	15,151	52,727	69,971	81,586
HMO/Clinic Plan Enrollment	75,554	87,109	88,835	87,030
TOTAL ENROLLMENT	90,705	139,836	158,806	168,616
Eligible Population	385,458	372,806	351,962	345,325

PPSP Monitoring Project

Concern on the part of key state-level decision makers regarding the potential harmful effects of a lock-in system on clients led to the development of a Monitoring Project to monitor implementation of PPSP and its impact on Medicaid recipients. The project is administered by the Michigan League for Human Services, a statewide nonprofit research and advocacy organization, under a grant from the Michigan Department of Social Services (MDSS).

The focus of the monitoring effort has been on tracking implementation of policies and procedures under the Plan, the adequacy of enrollment processes and information provided to clients, the ability of the Sponsor Specialist Office in Wayne County to perform its functions, client access to care under PPSP, and the protection of client rights.

Information on these issues is gathered through: (1) monthly surveys of randomly-selected recipients enrolled in PPSP; (2) regular interviews with Medicaid officials and the Sponsor Specialist staff; (3) review and analysis of telephone calls to the Sponsor Specialist Office; and (4) surveys of organizations and community groups in contact with the Medicaid population.

* Wayne County includes the City of Detroit and approximately 40 percent of the State's eligible Medicaid population.

PPSP Monitoring and Evaluation Committee

Ongoing oversight of the Project is being conducted by a twelve-member Monitoring/Evaluation Committee with representation from the MDSS Medical Services Administration (MSA), MDSS Office of Planning, Budgeting and Evaluation, Michigan House and Senate staff, physician groups, health maintenance organizations, Medicaid recipients, and advocacy groups. (See Appendix A for a list of Committee members.)

The Committee has met monthly since December 1982 to review progress reports on enrollment, the number and type of calls received by the sponsor specialist staff, the kinds of problems being encountered, the patterns of complaints involving patients, providers, and the sponsor specialist staff. Particular attention is given to the complaint/grievance process and its effectiveness in resolving problems.

Regular reports from the Monitoring Project staff are also a focus of Committee discussion. In the process of deliberations, the Committee has made numerous recommendations to MSA and the Steering Committee for corrective actions to improve the program and minimize the harmful effects on recipients. (The Committee's recommendations are included, beginning on page 23.)

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MONITORING PROJECT FINDINGS

1. Implementation of Policies and Procedures under the Plan

In the four years since the implementation of the PPSP experiment began, significant changes have occurred in the program with respect to client enrollment procedures and policies affecting provider participation.

Recipient Enrollment Procedures

Initially, virtually all recipient enrollments were made through telephone calls to the Sponsor Specialist Office by clients who were sent brochures about the program. Recipients who did not respond in the allotted time were "computer matched" and enrolled with a sponsor physician whom they had seen within the prior six months, or blindly assigned to one located in the same or adjoining zip code area where the individual lived. Both approaches proved to be administratively unworkable and disruptive to patients as well as physicians, and their use was abandoned for any clients other than those selected to be among the sample for formal PPSP evaluation.

For a short time, non-responding Medicaid recipients were "MSA assigned" which required a telephone authorization from DSS staff each time service was needed until the recipient selected a sponsor physician. This approach was equally problematic for everyone involved and was soon discontinued. Consequently, although selection of a sponsor physician (or HMO or CAP) is a mandatory requirement for AFDC and SSI recipients, those who do not make a choice or whose physician of choice is not an enrolled sponsor in PPSP, are not presently being forced to see another doctor. They remain in the traditional fee-for-service system for the present.

Instead of enrolling recipients by telephone through the Sponsor Specialist Unit, most enrollments are now processed through completion of a form in the local DSS office at the time of application or redetermination for public assistance, or in the physician's office at the time the recipient comes in for medical care. The forms are then sent directly to the MSA office in Lansing for processing. Periodically, general mailings have been sent directly to recipients informing them about the three health care options with an enrollment form which can be sent directly to the Medicaid office.

The vast majority of recipient enrollments (70.5 percent in the past year) are initiated in the local DSS office at the point of eligibility determination or redetermination. An additional 21 percent originate in the physician's office. For the most recent twelve-month period, almost 55,000 enrollment forms have been processed by the MSA office in Lansing although total enrollment only increased by about 12,000 during the same period. In part, this can be explained by declining caseloads and the estimated 2 percent of the population that loses Medicaid eligibility each month. It is believed that some of the enrollment forms are actually from persons already enrolled in the program.

Enrollment Forms Processed
(September 3, 1985 - August 29, 1986)

<u>Method of Enrollment</u>	<u># of Enrollment Forms</u>	<u>Percent of Total</u>
DSS District Office	38,595	70.5
Physician Office	11,672	21.3
Recipient Initiated	59	0.1
Other	<u>4,429</u>	<u>8.1</u>
TOTAL	54,755	100.0

Provider Participation Policies

Under the original program design, physicians who exceeded appropriate utilization standards would be prevented from participating in PPSP, or would subsequently be suspended without a prior hearing if already enrolled. Shortly after enrollments began, a lawsuit was filed to prevent further implementation by 22 individual providers and clinics, and by several Medicaid recipients. Belin, et. al v. Kheder et al. The lawsuit challenged the waiver of prior hearing provision, the limit of 1,500 enrollees per physician, and the prohibition against recipients directly accessing specialists' services.

In response to the lawsuit, MDSS reconsidered the 1,500 enrollee limit per physician and decided to honor existing physician-client relationships even if the result was a physician caseload of more than 1,500 enrollees. MDSS also withdrew the waiver of prior hearing provision in the physician contract. In the Court's October 1982 opinion dissolving the restraining order, the limit on enrollees per physician was raised to 2,000, and existing relationships between doctors and patients were ordered not to be disturbed.

Cost/utilization standards are still incorporated in the physician contract although no effort has been made to enforce them by sanctioning the providers who exceed the specified limits, or who violate any of the other requirements of the contract.

2. Provision of Information to Recipients about the Plan

General information about PPSP and the other case management option has been provided to recipients through (1) periodic direct mailings to recipients; (2) pamphlets and enrollment forms sent by local district offices at the time of application or eligibility redetermination; and (3) enrollment brochures available in physician offices. Additional material about the program is sent after the client is enrolled. Clients wanting more specific information, or needing assistance in choosing a health care provider, are instructed to call the Sponsor Specialist Office. A large percentage of the calls to the Sponsor Specialist Office relate to basic information about PPSP. In the past year, about 30 percent of the 21,000 calls to the Office were requests for information about the Plan.

The Monitoring Project's survey of Medicaid recipients enrolled in PPSP asks several questions to determine how well informed they were about their health care options. Based on the client questionnaire responses regarding this information, it was found that:

- a. 63 percent knew about the three plan options from which they could choose at the time of making a selection. The other 37 percent were not aware of their health care options.
- b. A little more than one-half stated that the Plan was explained to them before they made a choice, while the remainder indicated it was not explained to them.
- c. About one-half (51.4%) indicated that the information they received from DSS helped them to understand the Plan. The other half either didn't receive the information, didn't read it, or didn't find it helpful.
- d. Two-thirds felt prepared to make a choice of health plan at the time of enrollment. The other one-third did not feel prepared to choose a health plan.
- e. Over one-fourth seem to have received misleading information about what would occur if they did not select one of the three plans, and perhaps were coerced into making a choice.
- f. Those who were aware of their health care options generally felt the Department's information was helpful, had fewer access problems and were more satisfied with PPSP.
- g. Those who reported being uninformed about their health options or not ready to choose a doctor reported more access problems after they were enrolled in the program and were less satisfied with PPSP.
- h. A number of respondents to the survey and callers to the sponsor office reported being pressured to choose a particular health plan or had no idea how they were enrolled. In such cases, attempts are made to find out the source of misinformation and actions taken to correct the situation.

Monitoring Survey Responses - Information/Enrollment
1983-1986

	<u>Number</u>	<u>Percent</u>
Knowledge/readiness to select sponsor:		
(a) Knew about three options	444	(63.1)
(b) Didn't know about three options	260	(36.9)
Plan explained:		
(a) Yes it was	228	(51.7)
(b) No it was not	213	(48.3)

Monitoring Survey Responses - Information/Enrollment
1983-1986
(continued from page 8)

	<u>Number</u>	<u>Percent</u>
Respondent prepared to choose:		
(a) Respondent was prepared	228	(87.1)
(b) Respondent was unprepared	112	(32.9)
Needed assistance with form:		
(a) Needed assistance	49	(14.0)
(b) Did not need assistance	301	(86.0)
DSS information helpful:		
(a) Yes	676	(54.2)
(b) No	249	(20.0)
(c) Didn't read it	130	(10.4)
(d) Didn't receive it	193	(15.5)
Was told would happen if choice not made:		
(a) Would no longer get care	73	(15.4)
(b) DSS would select doctor	54	(11.4)
(c) Would lose Medicaid coverage	57	(12.0)
(d) Forced to see a doctor you don't know	127	(28.7)
(e) Would be asked to choose later	164	(34.5)

(See Appendix B for details)

Despite the multiple methods of providing information to Medicaid clients, there is still confusion among many recipients regarding their health care options, enrollment procedures, the consequences of failing to choose a physician, and how to access care once they are enrolled. Further efforts are needed to better inform the Medicaid population about the program.

3. Capacity of the Sponsor Office to Handle Calls about PPSP

The PPSP Sponsor Office in Wayne County was created to answer questions about the Plan, process enrollments, assist with changes, and resolve problems. Most client enrollments are no longer processed through the Sponsor Specialist Office, but instead are handled by the paper processing unit in Lansing. The number of telephone workers answering calls in the Sponsor Specialist Office has been reduced from eight to four since the Plan's inception, and additional responsibilities have been added to their work load, such as marketing the Plan to physicians. The figures below show the nature and frequency of calls received during the two past years.

PPSP Sponsor Office Activity

	1986		1985	
	<u>Number of Calls</u>	<u>Percent of Calls</u>	<u>Number of Calls</u>	<u>Percent of Calls</u>
Recipient Enrollments	383	1.8	1,833	5.7
Requests for Change in Sponsor, HMO, or Clinic Plan	4,993	23.7	5,187	16.0
Recipient Requests for Information	8,711	41.4	9,189	28.4
Provider Requests for Information	687	3.3	2,497	7.7
Specific Complaints/Problems	260	1.2	963	3.0
Provider Billing Information	322	1.5	3,562	11.0
Marketing Contacts to Physicians	709	3.4	3,542	10.9
Collateral Contacts	4,975	23.6	5,419	16.8
Follow-up on Complaints Referred by the Monitoring Project	81	0.4	--	--
Exceptions to PPSP				
Enrollment Processed	17	--	35	--
TOTAL	21,057	100.0	32,312	100.0

A detailed listing of PPSP Sponsor Office activities is included in Appendix F.

The Sponsor Specialist Office has consistently reported handling an average of 25-30 calls per staff person per day. Calls from recipients tend to be heaviest at the beginning and end of the month. This, in combination with the decreased size of the Sponsor Office Staff (from 8 to 4 telephone workers) and increased client enrollment, has led to reports of both recipients and providers having difficulty getting through on the telephone lines. A busy signal study conducted in May 1985 by Michigan Bell confirmed that 3,790 calls during a typical one-week period could not be completed because the telephone lines were tied up. This creates particular problems for recipients who do not have phones and must rely on neighbors or public telephones in order to call. The phone lines were especially jammed when clients were being computer matched, or blindly assigned, or when mass mailings were done regarding the Plan.

Two additional staff positions for the office were appropriated in the FY 1985-86 Department of Social Services budget. Only one of the new staff positions has been filled and because one telephone worker is on an indefinite leave, the size of the Sponsor Specialist Staff has not been increased.

Steps have been taken to shift all provider billing calls to the provider hotline in Lansing to help alleviate the telephone problem. The shift of provider billing calls to Lansing has been successful in reducing the number of such calls coming into the Sponsor Specialist Unit. A further telephone busy signal study by Michigan Bell has been requested to assess the current extent of this problem.

Responses to the recipient questionnaire over the last two years indicate that almost 80 percent of the respondents did not know about the Sponsor Office telephone number, and less than 10 percent had actually called the Sponsor Office. Of those who did try to call in the last two years, almost one-fourth reported that the telephone line was busy when they called. In an attempt to contact surveyed clients by telephone, it has become evident that large numbers of Medicaid recipients, perhaps as many as one-half, do not have phones, thereby exacerbating recipients' difficulties in contacting the Sponsor Specialist Office.

Monitoring Survey Responses - Sponsor Specialist Office
1985 - 1986

	<u>Number</u>	<u>Percent</u>
Familiarity with Sponsor Unit:		
(a) Knew about telephone number	179	(20.2)
(b) Didn't know about it	705	(79.8)

What happened if called:

(a) Called and got through	64	(76.2)
(b) Line was busy	20	(23.8)

(See Appendix B for details)

Complaint Follow-Up Activities

Problem solving for recipients who encounter difficulty with PPSP is one of the most critical functions of the Sponsor Specialist Office. When problems arise, clients who know about the office and can get through on the telephone line can get information, advice, and help in changing to a new sponsor (or HMO or CAP)*, or otherwise resolve their problems with the Plan.

If an access problem is urgent enough, the recipient may be immediately (or retroactively) disenrolled from the program and issued an unrestricted Medicaid card.

Client problems identified through the monitoring surveys are referred to the Sponsor Specialist Office for follow-up. About one-third of the returned surveys indicated some type of concern or complaint with the Medicaid Sponsor Plan. These ranged from difficulty accessing medical care to lack of information regarding the Sponsor Plan to general dislike for the program.

*Change in sponsor physician normally takes 2-6 weeks to process.

Summary of Comments and Complaints from Recipient Survey Responses
and Sponsor Office Records
1983-1986

	<u>Monitoring Survey Responses</u>	<u>Sponsor* Office Records</u>
Client Lacks Understanding/Information		
Regarding Case Management Plans	51	--
Enrollment Related Problems	39	170
Referrals to Specialist/Second Opinion Problems	65	49
Pharmacy/Medication Problems	29	8
Need for Change of Sponsor/Case Manager	26	--
Travel Difficulties to Sponsor Physician's Office	14	--
Comments about Sponsor Physician	32	--
Lack of Satisfaction with Care	20	16
Problems with Billing for Medicaid Services	7	30
Problems with Emergency Room Care	34	--
24-Hour Access Problems	12	97
Other Access Problems	3	38
HMO/Clinic Plan Concerns	4	41
Services Not Yet Needed	9	--
Problems with Other DSS Health Programs		
(Recipient Monitoring, GA Medical)	2	7
Concerns Regarding Medical Appropriateness of Care	--	16
Physician Requested Client Disenrollment	--	7
Recipient Moved Out of County and Needed to Disenroll	--	38
Children in Foster Care who Needed to Disenroll	--	23
Medicare Recipients who Needed to Disenroll	2	2
Other Exceptions to Enrollment in PPSP	1	7
Problems with Dental Care Related to PPSP	16	3
Positive PPSP General Comments	170	--
Negative PPSP General Comments	266	21
Client Hearing Requests to Disenroll from PPSP	--	2
General Medicaid Comments	<u>161</u>	<u>13</u>
 TOTAL	 963	 588

(See Appendix E and F for details)

Complaints expressed by survey respondents which required some follow-up action were referred to the Sponsor Specialist Unit. Examples of the kinds of issues requiring follow-up action were: (1) billings to recipients for emergency care; (2) indications of possible coercion by providers to enroll recipients in their case management option; (3) difficulties in finding physicians in some specialties willing to accept Medicaid; (4) problems with pharmacies that would not fill prescriptions ordered by physicians other than the sponsor doctor; and (5) requests for information about several specific aspects of the program.

*The figures in this column are incomplete because complaints were not categorized and separated out from other telephone calls until September 1984.

In most cases the action taken by the Sponsor Specialist Office Staff included one or more of the following:

- Telephone contact with client
- Correspondence to client
- Transmittal of printed material about PPSP
- Referral to MSA staff in Lansing for resolution

In many cases, telephone contact with the client is not possible, since an increasing number of recipients do not have telephones. As a result, the follow-up activity often consists of a form letter to clients asking them to contact the Sponsor Specialist Office if problems still exist.

In the past year, 81 problems were referred to the Sponsor Specialist Office by the Monitoring Project for follow-up. In addition, 162 other recipient complaints were handled by the Sponsor Specialist Office, and almost 5,000 requests for changes in sponsor were processed in response to client calls to the office.

In summary, the Sponsor Specialist Office performs a key role in informing recipients about PPSP and resolving problems which occur under the Plan. The traditional grievance resolution system within MDSS--the administrative hearing process--is inadequate for resolution of immediate problems such as those related to access when a sickness occurs; the Sponsor Specialist Office has both the authority and the necessary mechanisms to respond quickly. However, staffing problems and client difficulties in contacting the Office have hampered its effectiveness.

4. Geographic Accessibility to Sponsor Physician

Approximately 1,232 physicians throughout Wayne County are currently participating in PPSP (a slight drop from a year ago); 1,104 physicians have patients enrolled with them. An analysis by MSA staff for December 1985, indicated that 50 percent of the sponsor physicians (574) had fewer than 20 enrollees in their practice while 16 physicians (less than 2 percent) each have more than 550 enrollees. In addition, efforts are being made to enroll non-participating physicians requested by recipients rather than forcing the client to choose an unknown sponsor doctor.

The geographic distribution of Medicaid recipients and physicians participating in PPSP is uneven in some areas. An earlier analysis by the Medical Services Administration indicated several zip code areas within suburban/rural Wayne County where geographic access presents a potential problem. The survey responses indicated that:

- a. 80 percent of client enrollment requests are for physicians the clients were already seeing. Almost 90 percent of respondents are still with the same physician six months later.
- b. About two-thirds say it is easy to get to their physician's office and can get there in a half hour or less. One-third reported that access to their doctor's office was somewhat more difficult and took longer than 30 minutes.

- c. About one-fifth drive their car to their doctor's office, while the remainder rely on family, friends, public transportation, taxi cabs, or walking.
- d. Recipients who are linked up with sponsor physicians they have not previously seen for medical care reported greater difficulty with access to the doctor's office.

Monitoring Survey Responses - Geographic Accessibility to Sponsor Physician
1983 - 1986

	<u>Number</u>	<u>Percent</u>
How Doctor was Chosen:		
(a) Already seeing this doctor	1,344	(80.0)
(b) Sponsor Specialist Office helped choose	43	(2.6)
(c) Advice from friend/relative	85	(5.1)
(d) Doctor asked client to enroll	7	(0.0)
(e) Doctor's office is easy to get to	82	(4.9)
(f) Doctor isn't sponsor so picked one that was	110	(6.5)
(g) Other	9	(0.1)

Access to Doctor's Office:

(a) Easy to get to	696	(68.5)
(b) Between easy and difficult	231	(22.7)
(c) Difficult	89	(8.8)

Method of Transportation:

(a) Bus	276	(22.3)
(b) Walk	201	(16.3)
(c) Car	241	(19.5)
(d) Cab	80	(6.5)
(e) Friend or relative	437	(35.4)

Length of Travel Time:

(a) 0-1/2 hour	750	(72.6)
(b) 1/2 to 1 hour	213	(20.6)
(c) 1 to 2 hours	42	(4.1)
(d) Over 2 hours	7	(0.7)
(e) Don't know	21	(2.0)

Six-Month Follow-Up Survey

Still with Sponsor of
Original Enrollment:

(a) Yes	660	(87.4)
(b) No	95	(12.6)

(See Appendix B and C for details)

These results suggest that geographic accessibility to sponsor physicians is not a major problem for the majority of clients under PPSP. However, travel times and reliance on public transportation or others to take them present significant barriers for about one-third of them. Such persons were traditionally more likely to see a doctor for routine care near where they live, but go to their "real doctor" for more serious health problems. The lock-in feature of PPSP with one doctor complicates access to health care for persons who have utilized the system in this manner.

There have been periodic reports of sponsor physicians choosing to terminate their participation in the program, several involving large groups of physicians. Recent follow-up activity by the Sponsor Specialist Unit with nonparticipating physicians requested by recipients indicates that many are not interested in becoming sponsor doctors.

5. Access to Care Under PPSP

Assessment of the ability of Medicaid recipients to readily obtain needed health care services under PPSP is a major focus of the Monitoring Project. The client survey asks several questions relating to access in general, referrals to specialists, second medical opinions, and care during non-office hours. The responses indicate that:

- a. Over 80 percent of the respondents reported that a family member had gone to the doctor for care since enrolling in PPSP.
- b. About 30 percent reported a need to see a specialist and, of those, about 80 percent were assisted by their sponsor in obtaining a referral. Similar responses were reported in the six-month follow-up survey.
- c. Roughly one in ten recipients reported asking for a second medical opinion and, of those, about 70 percent were assisted by their sponsor in obtaining the second opinion.* These figures were slightly higher in the six-month follow-up survey.
- d. About one-fourth (23%) reported a need to contact their doctor after regular office hours and, of those, about half were successful. More than a third could not reach their doctor, or didn't know where to call and obtained care at an emergency room. After six months in the Plan, about 30 percent of respondents needed to contact their physician after regular office hours and over half reached their sponsor or already knew what to do. Almost 40 percent got no answer or didn't know where to call and went to the emergency room.
- e. A relatively small number of respondents reported any difficulty in having prescriptions dispensed under PPSP, less than 5 percent.
- f. About one-fourth reported going to a hospital emergency room for care and over 90 percent of those reported getting treatment. After six months in the Plan, about one-third reported going to an emergency room for care and 94 percent of those received care.

*Referrals for second medical opinion are required to be approved on request under a provision in the physician's contract with MDSS.

- g. Those who enrolled with doctors they were already seeing for medical care were more likely to need care since enrolling. They experienced fewer difficulties with referrals, second opinions, non-office hour care, and emergency room care. Their satisfaction with PPSP and their assessment of care under the Plan were also considerably higher.

Monitoring Survey Responses - Access to Care
1983 - 1986

	Initial Survey		6 Month Follow Up Survey	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
Needed Care since Enrolling in PPSP:				
(a) Yes	1,463	(84.2)	--	--
(b) No	275	(15.8)	--	--
Asked for Referral to Specialist:				
(a) Yes	544	(32.2)	279	(27.1)
(b) No	1,111	(65.8)	752	(72.9)
(c) Didn't know could ask	34	(2.0)	--	--
If Asked:				
(a) Assisted by sponsor with referral	442	(83.1)	222	(81.6)
(b) Not assisted by sponsor with referral	90	(16.9)	50	(18.4)
Asked for a Second Opinion:				
(a) Yes	162	(9.3)	81	(10.9)
(b) No	1,544	(88.9)	665	(89.1)
(c) Asked but sponsor refused	6	(0.3)	--	--
(d) Didn't know could ask	24	(1.4)	--	--
If Asked:				
(a) Sponsor helped to get second opinion	110	(70.1)	54	(73.0)
(b) Sponsor did not help	47	(29.9)	20	(27.0)
Needed Care During Non-Office Hours:				
(a) Yes	424	(24.3)	220	(29.6)
(b) No	1,294	(74.3)	524	(70.4)
(c) Didn't know could get it	24	(1.4)	--	--

Monitoring Survey Responses - Access to Care
1983 - 1986
(continued from page 16)

	Initial Survey		6 Month Follow Up Survey	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
If Needed:				
(a) Called sponsor and told what to do	222	(54.0)	116	(55.5)
(b) No answer, waited	38	(9.2)	20	(9.6)
(c) No answer or didn't know/ went to emergency room	111	(27.0)	63	(30.1)
(d) Didn't know where to call, waited	40	(9.7)	10	(4.8)

Went to Emergency Room for Care:*

(a) Yes	451	(26.1)	249	(33.2)
(b) No, didn't need to go	1,276	(73.9)	501	(66.8)

If Went:

(a) Got care	418	(95.0)	226	(93.8)
(b) Told not an emergency	22	(5.0)	15	(6.2)

Trouble Getting Prescriptions:

(a) Yes	25	(3.6)	--	--
(b) No	675	(96.4)	--	--

(See Appendix B and C for details)

Satisfaction with Care and Health Status

In the initial survey, satisfaction with care under PPSP was generally lower shortly after enrollment in the Plan. Increased satisfaction was reported by those who responded to the six-month follow-up survey, but the initial satisfaction level was also higher for this subgroup. It was still below pre-PPSP satisfaction levels.

About 12 percent of survey respondents during the past year thought the care they received was better under PPSP while five percent thought it was worse. Over 75 percent felt their care was the same.

Three-fourths of the respondents reported their health status as being either good or excellent. Only five percent indicated they were in poor health.

*Question was not limited to non-office hours which explains discrepancy in numbers with the previous question.

Monitoring Survey Responses - Satisfaction with Care/Health Status
1983 - 1986

	Initial Survey		6-Month Follow-Up Survey	
	No.	(%)	No.	(%)
Satisfaction with Care Before PPSP:				
(a) Satisfied	873	(84.4)	--	--
(b) Somewhat satisfied	98	(9.5)	--	--
(c) Not satisfied	49	(4.7)	--	--
(d) Haven't needed care	14	(1.4)	--	--
Satisfaction with Care Under PPSP:				
(a) Satisfied	692	(67.7)	563	(75.3)
(b) Somewhat satisfied	138	(13.5)	106	(14.2)
(c) Not satisfied	115	(11.3)	60	(8.0)
(d) Haven't needed care	77	(7.5)	19	(2.5)
Assessment of Care Under PPSP:				
(a) Better	88	(12.8)	--	--
(b) Same	540	(78.7)	--	--
(c) Worse	35	(5.1)	--	--
(d) Haven't needed care	23	(3.4)	--	--
Assessment of Health Status:				
(a) Excellent	213	(30.3)	--	--
(b) Good	330	(46.9)	--	--
(c) Fair	126	(17.9)	--	--
(d) Poor	34	(4.8)	--	--

(See Appendix B and C for details)

6. Analysis of Monitoring Survey Responses by Selected Characteristics

An analysis of the Monitoring Survey results between January 1983 and April 1986 was undertaken to determine if any patterns existed in recipient responses based on: (1) method of enrollment in PPSP; (2) recipients' prior relationship with their sponsor doctor; (3) recipients' familiarity with their health care options and preparedness to choose at the time of enrollment; and (4) satisfaction level with PPSP. (See Appendix D for details.)

Findings Related to Enrollment Method

1. Almost all respondent recipients who enrolled by telephone or mail chose physicians they were already seeing and were more likely than other enrollees to think that the information from DSS was useful. They were also somewhat more satisfied with PPSP than those enrolled through other methods.

2. Assigned respondent recipients were less likely to need care; when they did, however, they were more likely to experience difficulty in getting referrals,* non-office hour care, and emergency room care. They are also less satisfied with care under PPSP than other enrollees.
3. Respondent district office enrollees indicated that access to their doctor's office was somewhat more difficult than other PPSP participants, but that their access to referrals, care during non-office hours, and emergency room care was somewhat better than other PPSP participants.
4. Respondent clients enrolled through physicians' offices were somewhat less knowledgeable about their options, somewhat less prepared to make a choice, and less likely to find the DSS information helpful than other participants in PPSP. They were also more likely to need care since enrolling, and they experienced fewer difficulties obtaining emergency room care than other survey respondents.

Findings Related to Previous Relationship with Sponsor Doctor

1. Eighty percent of all recipients responding to the survey chose a doctor who they were already seeing for medical care as their sponsor physician. This group was somewhat more knowledgeable/ready to choose a physician, had easier access to their doctor's office, was more likely to need care since enrolling, and experienced fewer difficulties with referrals, non-office hour care, and emergency room care. Their satisfaction with PPSP and their assessment of care under PPSP was also considerably higher than the other group of PPSP enrollees.
2. The twenty percent of survey respondents who did not select a sponsor physician that they had already seen for medical care were less knowledgeable/ready to enroll and less likely to need care since enrolling. Proportionately, however, they experienced more difficulty with access to their doctor's office, referrals, and second opinions. They were less satisfied with PPSP and their assessment of care under PPSP was also lower.

Findings Related to Knowledge/Readiness to Choose a Doctor

1. Sixty-five percent of the survey respondents were aware of their health care options and/or felt prepared to select a sponsor doctor at the time of enrollment. This group felt the Department's information was more helpful than those who were not knowledgeable/prepared to choose a doctor and they were somewhat more likely to select a doctor they were already seeing. Their access to the doctor's office, referrals, and second opinions was higher than the other group, and they were more satisfied with PPSP.

* Referrals include those requested for specialty care which was at the sponsors'/case manager's discretion to provide, and those requested for a second medical/surgical opinion; the latter category of referrals were required of the sponsor physician by contract.

2. Those who were not aware of their health care options and/or were unprepared to choose a sponsor didn't think the DSS information was as helpful or didn't receive it. Their access to the doctor's office was somewhat more difficult and they experienced more problems with referrals and second opinions under PPSP. They were not as satisfied with PPSP as the other group, although their assessment of care under the program and their perceived health status was about the same.

Findings Related to Satisfaction Level

1. As might be expected, those satisfied with PPSP were more likely to have chosen a doctor they were already seeing, be aware of their health options/prepared to choose, and to have found the Department's information helpful. Access to their doctor's office was easier for the satisfied group and they had less difficulty with referrals and second opinions. They were also less likely to need care during non-office hours.
2. The somewhat satisfied and not satisfied groups were less likely to be with sponsor physicians they had seen before for medical care and felt less knowledgeable/prepared to make a choice. The DSS information was less helpful to them and access to their doctor's office was more difficult for them. They were more likely to need referrals, second opinions, and emergency room care, but had more problems obtaining such help.

7. Interviews with Sponsor Specialist Staff

The Monitoring Project staff conducts informal interviews on a monthly basis with the Sponsor Specialist Unit staff in Wayne County and with the staff of the Medical Services Administration in Lansing. The purpose of these informal interviews is to identify issues and problems which may require further attention. During the past year the following issues were raised:

- Clients and providers do not seem to fully understand the referral process within PPSP for care from specialists.
- Sponsor Specialist Unit has become a clearinghouse for all Medicaid questions, such as billing problems, dental and optical services, medical equipment, etc. The staff state that there is no general number that clients can call for this information and that frequently the designated community service representatives cannot answer the client's questions because they are not trained in Medicaid policy.
- Clients in the majority of cases are not receiving the booklet "Select Your Plan for Health Care" until after they have enrolled in one of the options. When questioned by Sponsor Specialist staff workers, most clients state that the booklet was not included in the packet of information they received at intake or redetermination.
- Some doctors have hospital switchboard numbers listed as 24-hour access numbers. This has caused some confusion for clients needing care after normal office hours. Other doctors do not yet have a proper arrangement regarding compliance with the 24-hour access provision of the contact.

- Clients claim they are having difficulty contacting the Sponsor Specialist Unit. Phone lines are frequently busy.
- Signature of client is not always on enrollment form and yet forms are processed. Some clients state they did not sign because they did not want the doctor as their sponsor.
- According to staff, there seems to be a reduction in the number of sponsors willing to accept new Medicaid patients. Staff has also received some calls from clients who have been enrolled with doctors for months and do not find out until they seek care that the doctor will not see them. In many of these cases, the doctor's name appears on the sponsor list as a doctor willing to accept new Medicaid so the client enrolls with that sponsor. The office policy however is not to accept new patients. These doctors have received case management fees for these clients. The staff voice some concerns about this since there is no retroactive recoupment of the case management fees, and the clients do not have access to these doctors.
- All members of the problem solving staff of the Sponsor Specialist Unit state they need more training since they handle calls which cover a variety of topics and there does not seem to be any other place to direct these client calls.
- Sponsor Specialist staff members state there are problems when doctors leave practice or relocate. In some cases, the doctor's name appears on the client's Medicaid card long after the doctor is gone. In other cases, clients state they were not notified that their sponsor was leaving practice or relocating and they have been assigned to another doctor at the site. Some members of the staff state clients should not routinely be assigned to partners in the practice by the Paper Processing Unit in Lansing.

Some sponsors do not notify Lansing when they are leaving practice so their names appear on the sponsor list resulting in clients requesting them as sponsors when they are not participating in PPSP.

- Entire families are being enrolled with sponsors even though only one family member requested to be enrolled and other members do not yet have doctors.
- Wrong telephone numbers for some sponsors are listed on client's Medicaid cards.
- PPSP participation is optional for some Medicaid clients in Wayne County, yet they are not being advised of this. Staff members state some clients who do not need to enroll in PPSP have done so because they did not know there was a choice.
- Sponsor Specialist workers feel they should be able to order replacement cards at any time, not just when clients are requesting a change of provider.

- Adult foster care patients enrolled in large clinics are unable to develop a relationship with a sponsor as they see a different doctor each time they go into the clinic. Clients who are capable of making choices are not consulted; guardians have no input if they request a specific sponsor not involved with the clinics. Choice of sponsor is made by those running the AFC homes.
- Some doctors refuse to call the Client Information System (CIS) for information, stating that it wastes time.
- Clients enrolled at a large clinic had difficulty getting care when the clinic closed its neighborhood sites.
- Sponsor Specialist staff state that several problems have surfaced related to the Recipient Monitoring program. Staff state they have received calls from providers who are confused about what program their patients are participating in, PPSP or Recipient Monitoring. Many clients call thinking they are being punished for excessive use when they are asked to enroll in PPSP. Also some clients with legitimate high use are in Recipient Monitoring when they should be in PPSP. Staff also state that there does not seem to be a uniform system within the district office structure to deal with Recipient Monitoring. Lists of service workers provided by Wayne County DSS are not accurate as offices have since reorganized.

SUMMARY OF MONITORING AND EVALUATION COMMITTEE RECOMMENDATIONS

The Monitoring and Evaluation Committee has been meeting on a monthly basis since December 1982 to discuss implementation of the Physician Primary Sponsor Plan. This oversight process has enabled the diverse groups interested in the Plan to review progress and make recommendations, where appropriate, to help achieve the pilot's objectives.

The recommendations adopted by the committee since the beginning of the pilot project are presented below in chronological order:

1. General Principles Regarding PPSP Enrollment

Client enrollments should focus on those recipients who have established relationships with physicians who are enrolled as sponsor doctors under the Plan. Those recipients with nonparticipating physicians should not be enrolled at this time.

The success of PPSP depends not only on increasing the number of enrollees, but also on adequate attention to the necessary systems and procedures for the smooth functioning of all parts of the Project.

New enrollment methods should be implemented on a pilot basis in order to perfect the procedures and assess their impact on all affected parties prior to implementation on a county-wide basis.

Adequate information on all available options for medical care should be provided to recipients at the time they are asked to choose between PPSP, health maintenance organizations, or capitated ambulatory plans.

2. Enrollment of Nonparticipating Physicians

More aggressive efforts should be undertaken to enroll non-sponsor physicians in the Plan.

3. Client Incentives to Participate in PPSP

Recipients should be provided with incentives to enroll in the Plan. The elimination of the pharmacy copayment for PPSP participants would be an important step in this direction.

4. Client-Initiated Enrollment and Informed Choice

A notice should be mailed to recipients explaining their health care options, how to enroll, and where to get additional information regarding the various alternatives available to them.

5. County Office Enrollment Process

A county office initiated process which enrolls clients at intake or redetermination should be implemented on a pilot basis in seven or eight district offices.

6. Physician-Initiated Enrollment Process

The physician-initiated process should include a DSS enrollment form and approved marketing materials to be distributed to recipients during regular office visits which the client then mails to the Medical Services Administration. The enrollment form should contain a reference to other options available and explain how to obtain additional information.

7. Enrollment of the Evaluation Experimental Group

Special procedures should be established to enroll recipients from the Evaluation Experimental Group who either do not sign up voluntarily, or whose physicians are not sponsors.

8. Monitoring of 24-Hour Access

The 24-hour access to care provision of the provider contract should be monitored by the Monitoring Project Staff with specific steps for correcting and enforcing violations to be undertaken by the Department of Social Services.

9. Maintenance of the Problem-Solving Function in Wayne County

The PPSP Sponsor Specialist Unit should be maintained in Wayne County, and to the extent possible, it should be structured in such a way that current staff can be retained.

10. Expansion of the Sponsor Specialist Office

The Sponsor Specialist Unit in Wayne County should be expanded to allow greater client access to this staff. On the basis of the most recent "busy signal study," as well as client and provider complaints it was recommended that two additional telephone workers be added.

11. Expansion of PPSP Outside of Wayne County

Preliminary investigation should be undertaken by the Medical Services Administration to identify other areas of the State in which to introduce PPSP pending the final performance data and analysis of the effects of PPSP on Medicaid utilization being conducted by the DSS Evaluation Unit.

12. Mandatory Enrollment for All Medicaid Recipients or Only High and Moderate Users

A decision regarding enrollment limitations should be held until the full evaluation has been completed, a study of the nonusers has been completed and physician participation attitudes have been assessed.

13. Assurances of Quality Care

The evaluation unit should implement a quality of care monitoring mechanism for PPSP which compares the frequency of selected health outcome indicators among the experimental and control groups in the present evaluation. Quality care assessment should be integrated into the design and expansion of future case management initiatives.

14. Adequate Staffing to Implement and Expand PPSP

Additional positions appropriated for the Wayne County Sponsor Specialist office should be filled. Expansion outside of Wayne County should proceed only if the necessary staff support is available.

15. Consideration of Alternative Reimbursement Methods

The Medical Services Administration should consider new and innovative health care systems such as the Health Insuring Organization and continue to involve the Monitoring and Evaluation Committee in concept development.

16. Criteria for Expansion of PPSP

In selecting counties in which to expand, the following criteria should be considered:

- Volume of Medicaid recipients
- HMO and CAP involvement
- Cooperation of local DSS offices
- Provider and community involvement
- The existence of medical care access problems

17. Suggested Alterations to PPSP in Wayne County

- Develop more explicit guidelines for exemption from mandatory participation in PPSP.
- Explore additional positive incentives for client participation,
- Revise, update, and better coordinate the provision of information to Medicaid recipients about PPSP.
- Develop a quality assurance component.
- Increase coordination of reporting and follow-up on all grievances and alleged contract violations.
- Reorganize the units involved in PPSP and specialize staff duties.
- Increase educational efforts aimed at the provider community.
- Explore addition of a risk factor in physician reimbursement.
- Survey county caseworkers regarding their perception of PPSP and the enrollment process to determine the need for additional training or materials.
- Better coordinate PPSP and the Recipient Monitoring Program.
- Develop informational materials for recipients which do not require the ability to read.

18. Continuation of PPSP Evaluation

The evaluation of PPSP should be continued after HCFA grant requirements have been fulfilled and the additional analysis of the data should be completed through the DSS Office of Planning, Budgeting, and Evaluation.

PPSP MONITORING AND EVALUATION COMMITTEE

Membership

Dorris Bennette, Metro Detroit Welfare Reform Coalition
Wayne Bradley/Elaine Lee, Comprehensive Health Services of Detroit, Inc.
Steve Anderson, House Fiscal Agency
Larry Drost, Michigan Association of Osteopathic Physicians and Surgeons
Bill Fairgrieve, Michigan League for Human Services
Maryann Ford, Michigan State Medical Society
Sally Hetrick, Medical Services Administration, MDSS
Gloria Martinez, Community Welfare Rights Organization
Kathleen Gmeiner, Michigan Legal Services
Kathy Sarb, Sponsor Specialist Office, Medical Services Administration, MDSS
Doug Kosinski, Office of Planning, Budget, and Evaluation, MDSS
John Walker, Senate Fiscal Agency

Other Participants

Champa Bhatia, Medical Services Administration, MDSS
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Randy Knapp, MDSS
Beverley McDonald, Michigan League for Human Services
Gloria McKinney, Detroit Health Department
Carnel Rucker, Michigan HMO Plans
Kris Sage, Wayne County Department of Social Services
Judy Wilson, Medical Services Administration, MDSS

COMPARISON OF RESULTS OF MONITORING PROJECT CLIENT SURVEYS

(Project Report Periods Jan. 83 - Aug. 86)

	Jan. 83- Aug. 83 M 854 R 400	Sept. 83 - Aug. 84 M 650 R 284	Sept. 84 - Aug. 85 M 1200 R 562	Sept. 85 - Aug. 86 M 1200 R 533
1. How respondents heard about PPSP	No. %	No. %	No. %	No. %
(a) DSS (worker)	55 13.8	36 12.7	66 16.9	NA 0.0
(b) Health Provider	166 41.5	114 42.3	150 38.4	NA 0.0
(c) Friend/Relative	55 13.8	20 8.5	11 2.8	NA 0.0
(d) DSS Mailing	NA 0.0	26 9.2	155 39.6	NA 0.0
(e) Other	12 3.0	8 3.2	5 1.3	NA 0.0
(f) NR	112 28.0	69 24.6	4 1.0	NA 0.0
2. How respondent enrolled				
(a) Client Selected Provider by Phone	55 68.8	133 61.0	NA 0.0	NA 0.0
(b) DSS Assigned Provider to Client	20 25.0	42 25.8	NA 0.0	NA 0.0
(c) Client Enrolled through DSS office	NA 0.0	45 37.2	114 36.8	NA 0.0
(d) Client Enrolled through Doctor's office	NA 0.0	44 36.4	204 52.2	NA 0.0
(e) Client Claims Does Not Know	0 0.0	7 5.8	32 8.2	NA 0.0
(f) NR	5 6.3	12 4.2	11 2.8	NA 0.0
3. How Doctor was chosen				
(a) Already seeing this doctor	316 79.0	200 70.4	429 76.3	399 74.9
(b) Sponsor Specialist Office Helped Choose	16 4.0	14 8.6	4 2.3	9 1.7
(c) Advice from Friend/Relative	9 2.3	6 2.1	34 6.0	36 6.7
(d) Doctor asked Client to Enroll (mail)	5 1.3	2 1.2	NA 0.0	NA 0.0
(e) Doctor's office is easy to get to	NA 0.0	NA 0.0	24 14.0	58 10.9
(f) Other	5 1.3	4 2.5	NA 0.0	NA 0.0
(g) Doctor isn't sponsor so picked one that was	NA --	NA 0.0	3 1.8	4 0.7
(h) NR	49 12.3	32 11.3	2 1.2	27 5.1

M = number of surveys mailed

R = number of surveys responses

NR = no response

NA = question not included on survey for this time period

4. Knowledge/Readiness to Select Sponsor

- (a) Knew about three options
(b) Didn't know about three options

5. Plan was explained

- (a) Yet it was
(b) No it was not explained
(c) NR

6. Was Respondent prepared to choose

- (a) Respondent was prepared to choose
(b) Respondent not prepared to choose
(c) NR

7. Needed Assistance with form

- (a) Yes needed assistance
(b) Did not need assistance
(c) NR

8. Was OSS Information Helpful?

- (a) Yes
(b) No
(c) Didn't read it
(d) Didn't receive it
(e) NR

Jan. 83 - Aug. 83 M 854 R 400		Sept. 83 - Aug. 84 M 650 R 284		Sept. 84 - Aug. 85 M 1200 R 562		Sept. 85 - Aug. 85 M 1200 R 533	
No.	\$	No.	\$	No.	\$	No.	\$
NA	0.0	NA	0.0	104	60.8	340	63.8
NA	0.0	NA	0.0	67	39.2	193	36.2
NA	0.0	36	54.5	192	49.1	NA	0.0
NA	0.0	27	40.9	186	47.6	NA	0.0
NA	0.0	3	4.5	13	3.3	NA	0.0
NA	0.0	NA	0.0	228	66.8	NA	0.0
NA	0.0	NA	0.0	112	32.8	NA	0.0
NA	0.0	NA	0.0	1	0.3	NA	0.0
NA	0.0	NA	0.0	49	12.5	NA	0.0
NA	0.0	NA	0.0	301	76.5	NA	0.0
NA	0.0	NA	0.0	43	11.0	NA	0.0
207	51.8	91	41.7	88	51.5	290	54.4
89	22.3	56	25.7	25	14.6	79	14.8
58	14.5	37	17.0	17	9.9	18	3.4
NA	0.0	8	3.7	41	24.0	144	27.0
46	11.5	26	11.9	0	0.0	2	0.4

	Jan. 83 - Aug. 83 M 854 R 400	Sept. 83 - Aug. 84 M 650 R 284	Sept. 84 - Aug. 85 M 1200 R 562	Sept. 85 - Aug. 85 M 1200 R 533
9. What were you told would happen if you did not choose?	No. %	No. %	No. %	No. %
(a) Would no longer get care	NA 0.0	8 6.6	35 6.2	30 5.6
(b) DSS would select doctor	NA 0.0	11 9.1	43 11.0	NA 0.0
(c) You would lose Medicaid coverage	NA 0.0	NA 0.0	16 9.4	41 7.7
(d) Forced to see a doctor you don't know	NA 0.0	NA 0.0	34 19.9	93 17.3
(e) Would be asked to choose after	NA 0.0	NA 0.0	49 28.7	115 21.6
(f) NR	NA 0.0	NA 0.0	62 36.3	255 47.8
10. Familiarity with Sponsor Unit				
(a) Knew about telephone number	NA 0.0	NA 0.0	56 32.7	123 23.1
(b) Didn't know about it	NA 0.0	37 30.6	297 52.8	408 76.8
(c) Called and got through	142 35.5	103 36.3	33 5.9	31 5.8
(d) Line was busy	NA 0.0	NA 0.0	7 4.1	13 2.4
(e) Did not call the number	209 52.3	126 44.4	334 59.4	462 86.7
11. Access to doctor's office				
(a) Easy to get to	246 61.5	183 64.4	267 68.3	NA 0.0
(b) Between easy and difficult	83 20.8	58 20.4	90 23.0	NA 0.0
(c) Difficult	33 8.3	23 8.1	33 8.4	NA 0.0
(d) NR	38 9.5	20 7.0	1 0.3	NA 0.0
12. Method of transportation				
(a) Bus	159 39.8	55 19.4	62 15.4	NA 0.0
(b) Walk	82 23.0	61 18.0	68 17.4	NA 0.0
(c) Car	60 15.0	76 26.8	105 26.9	NA 0.0
(d) Cab	49 12.3	13 4.6	18 4.6	NA 0.0
(e) Friend or Relative	115 28.8	105 37.0	137 35.0	NA 0.0

	Jan. 83 - Aug. 83 M 854 R 400	Sept. 83 - Aug. 84 M 650 R 284	Sept. 84 - Aug. 85 M 1200 R 562	Sept. 85 - Aug. 85 M 1200 R 533
13. Length of travel time	No. %	No. %	No. %	No. %
(a) 0-½ hour	262 65.5	193 68.0	295 75.4	NA 0.0
(b) ½ to 1 hour	84 21.0	48 16.9	81 20.7	NA 0.0
(c) 1 to 2 hours	24 6.0	11 3.9	7 1.8	NA 0.0
(d) Over 2 hours	2 .5	3 1.1	2 0.5	NA 0.0
(e) Don't know	11 2.8	8 2.8	2 0.5	NA 0.0
(f) NR	17 4.3	21 7.4	4 1.0	NA 0.0
14. Needed care since enrolling PPSP				
(a) Yes	327 81.8	212 74.6	462 82.2	462 86.7
(b) No	56 14.0	53 18.7	97 17.3	69 12.9
(c) NR	17 4.3	19 6.7	3 0.5	2 0.4
15. Asked for Referral to Specialist				
(a) Yes	128 32.0	105 37.0	167 29.7	144 27.0
(b) No	200 50.0	163 57.4	386 68.7	362 67.9
(c) Didn't know could ask	NA 0.0	NA 0.0	8 4.7	26 4.9
(d) NR	72 18.0	16 5.6	1 0.2	1 0.2
16. If asked,				
(a) Assisted by sponsor with referral	96 75.0	78 74.3	129 77.3	139 93.3
(b) Not assisted by sponsor with referral	25 19.9	21 20.0	34 20.4	10 6.7
(c) NR	7 5.5	6 5.7	4 2.4	0.0 0.0
17. Asked for a Second Opinion				
(a) Yes	41 10.3	36 12.7	55 9.8	30 5.6
(b) No	339 84.8	234 82.4	489 87.0	482 90.4
(c) Asked but sponsor refused	NA 0.0	NA 0.0	1 0.6	5 0.9
(d) Didn't know could ask	NA 0.0	NA 0.0	12 7.0	12 2.2
(e) NR	20 5.0	14 4.9	5 0.9	4 0.2

	Jan. 83 - Aug. 83 M 854 R 400	Sept. 83 - Aug. 84 M 650 R 284	Sept. 84 - Aug. 85 M 1200 R 562	Sept. 85 - Aug. 85 M 1200 R 533
18. If asked,	No. \$	No. \$	No. \$	No. \$
(a) Sponsor helped to get second opinion	25 61.0	21 58.3	38 69.1	26 74.2
(b) Sponsor did not help	10 24.4	12 33.0	16 29.1	9 25.7
(c) NR	6 14.6	3 8.3	1 1.8	0 0.0
19. Needed care during non-office hours				
(a) Yes	87 21.8	66 23.2	130 23.1	141 26.5
(b) No	297 74.3	200 70.4	422 75.1	375 70.4
(c) Didn't know I could get it	NA 0.0	NA 0.0	9 1.6	15 2.8
(d) NR	15 3.8	18 6.3	1 0.2	2 0.4
20. If need,				
(a) Called sponsor and told what to do	41 45.6	29 43.9	77 58.8	75 52.4
(b) No answer, waited	6 6.7	5 7.6	8 6.1	19 13.3
(c) No answer or didn't know/went to ER	26 28.9	19 28.8	30 22.9	36 25.2
(d) Didn't know where to call, waited	10 11.1	4 6.1	13 9.9	13 9.1
(e) Other	2 2.2	3 4.5	3 2.3	0 0.0
(f) NR	5 5.6	6 9.1	0 0.0	0 0.0
21. Went to Emergency Room for Care				
(a) Yes	84 21.0	74 26.1	133 23.7	160 30.0
(b) No, didn't need to go	298 74.5	182 64.1	427 76.0	369 69.2
(c) NR	18 4.5	28 9.9	1 0.2	4 0.8
22. If went,				
(a) Got care	76 90.5	68 91.9	123 92.5	151 94.4
(b) Told not an emergency	5 6.0	4 5.4	4 3.0	9 5.6
(c) NR	3 3.6	2 2.7	6 4.5	0 0.0

Jan. 83 -
Aug. 83
M 854
R 400

Sept. 83 -
Aug. 84
M 650
R 284

Sept. 84 -
Aug. 85
M 1200
R 562

Sept. 85 -
Aug. 85
M 1200
R 533

23. Trouble getting prescriptions

- (a) Yes
(b) No
(c) No Response

No.	\$	No.	\$	No.	\$	No.	\$
NA	0.0	NA	0.0	6	3.5	19	3.6
NA	0.0	NA	0.0	164	95.9	511	95.9
NA	0.0	NA	0.0	1	.6	3	0.6

24. Satisfaction with care before PPSP

- (a) Satisfied
(b) Somewhat satisfied
(c) Not satisfied
(d) Haven't needed care
(e) NR

345	86.3	213	75.0	315	80.6	NA	0.0
25	6.3	28	9.9	45	11.5	NA	0.0
12	3.0	16	5.6	21	5.4	NA	0.0
1	.3	5	1.8	8	2.0	NA	0.0
17	4.3	22	7.7	2	0.5	NA	0.0

25. Satisfaction with care under PPSP

- (a) Satisfied
(b) Somewhat satisfied
(c) Not satisfied
(d) Haven't needed care
(e) NR

256	64.0	171	60.2	265	67.8	NA	0.0
46	11.5	35	12.3	57	14.6	NA	0.0
37	9.3	38	13.4	40	10.2	NA	0.0
33	8.3	17	6.0	27	6.9	NA	0.0
28	7.0	23	8.1	2	0.5	NA	0.0

26. Assessment of care under PPSP

- (a) Better
(b) Same
(c) Worse
(d) Haven't needed care
(e) NR

NA	0.0	NA	0.0	19	11.1	69	12.9
NA	0.0	NA	0.0	136	79.5	404	75.8
NA	0.0	NA	0.0	5	2.9	30	5.6
NA	0.0	NA	0.0	0	0.0	23	4.3
NA	0.0	NA	0.0	11	6.4	7	1.3

27. Assessment of health status

- (a) Excellent
(b) Good
(c) Fair
(d) Poor
(e) NR

NA	0.0	NA	0.0	35	20.5	178	33.5
NA	0.0	NA	0.0	89	52.0	241	45.2
NA	0.0	NA	0.0	34	19.9	92	17.3
NA	0.0	NA	0.0	13	7.6	21	3.9
NA	0.0	NA	0.0	0	0.0	1	0.2

PPSP MONITORING PROJECT
Six Month Follow-up Client Survey

	Apr. 83- Aug. 83 M 148 R 100	Sept. 83- Aug. 84 M 249 R 148	Sept. 84- Aug. 85 M 413 R 206	Sept. 85- Aug. 86 M 539 R 301
Are you still with the original Sponsor you enrolled with?				
Yes	93 (93.0)	128 (86.5)	174 (84.5)	265 (88.0)
No	7 (7.0)	20 (13.5)	32 (15.5)	36 (12.0)
NR	--	--	--	--
Have you or anyone in your family needed to see a specialist since enrolling in PPSP?				
Yes	49 (49.0)	57 (38.5)	71 (34.5)	102 (33.9)
No	50 (50.0)	89 (60.1)	135 (65.5)	199 (66.1)
NR	1 (1.0)	2 (1.4)	--	--
If yes, did your Sponsor help you get in to see this doctor?				
Yes	36 (73.5)	41 (71.9)	61 (85.9)	84 (82.4)
No	10 (20.4)	13 (22.8)	9 (12.7)	18 (17.6)
NR	3 (6.1)	3 (5.3)	1 (1.4)	--
Have you or anyone in your family wanted to get a second opinion since enrolling in PPSP?				
Yes	15 (15.0)	15 (10.1)	20 (9.7)	31 (10.3)
No	82 (82.0)	127 (85.8)	186 (90.3)	270 (89.7)
NR	3 (3.0)	6 (4.1)	--	--
If yes, did your Sponsor help you get into see this other doctor?				
Yes	10 (66.7)	10 (66.7)	14 (70.0)	20 (64.5)
No	2 (13.3)	3 (20.0)	4 (20.0)	11 (35.5)
NR	3 (20.0)	2 (13.3)	2 (10.0)	--

Apr. 83- Aug. 83 M 148 R 100	Sept. 83- Aug. 84 M 249 R 148	Sept. 84- Aug. 85 M 413 R 206	Sept. 85- Aug. 86 M 539 R 301
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Have you needed to see your Sponsor on weekend or evenings when the office is normally closed?

Yes	36 (36.0)	47 (31.8)	62 (30.1)	75 (24.9)
No	56 (56.0)	98 (66.2)	144 (69.9)	226 (75.1)
NR	8 (8.0)	3 (2.0)	--	--

If yes, what happened?

- Already knew what to do	7 (18.4)	15 (27.3)	15 (24.2)	25 (33.3)
- Called and told what to do	11 (28.9)	10 (18.2)	14 (22.6)	19 (25.3)
- Tried to call no answer waited until office reopened	2 (5.3)	8 (14.5)	3 (4.8)	7 (9.3)
- Tried to call no answer went to emergency room	3 (7.9)	7 (12.7)	15 (24.2)	8 (10.7)
- Didn't know where to call waited until office reopened	3 (7.9)	3 (5.5)	2 (3.2)	2 (2.7)
- Didn't know where to call went to emergency room	4 (10.5)	8 (14.5)	9 (14.5)	9 (12.0)
- Other	8 (21.0)	3 (5.5)	4 (6.5)	3 (4.0)
- NR	--	1 (1.8)	--	2 (2.7)

Needed to go to emergency room under PPSP?

Yes	31 (31.0)	47 (31.7)	74 (35.9)	97 (32.2)
No	66 (66.0)	99 (66.9)	132 (64.1)	204 (67.8)
NR	3 (3.0)	2 (1.4)	--	--

If yes, assisted:

Yes	29 (93.5)	37 (78.7)	71 (95.9)	89 (91.8)
No	2 (6.5)	5 (10.6)	--	8 (8.2)
NR	--	5 (10.6)	3 (4.1)	--

Satisfied with care under PPSP?

Yes	66 (66.0)	105 (70.9)	163 (79.1)	229 (76.1)
No	14 (14.0)	15 (10.1)	8 (3.9)	23 (7.6)
Somewhat	17 (17.0)	18 (12.2)	32 (15.5)	39 (13.0)
No care needed	2 (2.0)	4 (2.7)	3 (1.5)	10 (3.3)
NR	1 (1.0)	6 (4.1)	--	--

ANALYSIS BY ENROLLMENT METHOD

PPSP Monitoring Survey Results

	Phone/Mail (N = 517)	Assigned (N = 43)	District Office (N = 617)	Physician Office (N = 352)	Total (N = 1529)
1. How respondent enrolled in PPSP					
a. Client selected provider by phone/mail	34%	-	-	-	34%
b. DSS assigned provider to client	-	3%	-	-	3%
c. Client enrolled through district office	-	-	40%	-	40%
d. Client enrolled through physician office	-	-	-	23%	23%
2. Client's relationship with sponsor doctor	(n = 513)	(n = 43)	(n = 586)	(n = 323)	(n = 1465)
a. Client was already seeing this doctor	97%	-	73%	76%	80%
b. Client was not already seeing this doctor	3%	100%	26%	23%	20%
3. Client's knowledge/readiness to choose a sponsor doctor	(n = 59)	(n = 0)	(n = 530)	(n = 312)	(n = 901)
a. Client knew about options/was prepared to choose	72%	-	69%	60%	66%
b. Client did not know about options/was not prepared to choose	29%	-	32%	40%	35%
4. Was DSS information helpful?	(n = 411)	(n = 38)	(n = 417)	(n = 127)	(n = 993)
a. Yes	67%	55%	58%	42%	59%
b. No/Didn't receive it	23%	24%	37%	49%	32%
c. Didn't read it	11%	21%	6%	9%	9%
5. What client thought would happen if didn't choose a doctor	(n = 20)	(n = 0)	(n = 206)	(n = 71)	(n = 297)
a. Would no longer get care/lose Medicaid coverage	50%	-	50%	44%	49%
b. DSS would select doctor/client asked to choose later	50%	-	51%	56%	52%
6. Access to doctor's office	(n = 473)	(n = 36)	(n = 257)	(n = 247)	(n = 1013)
a. Easy to get to	71%	67%	58%	74%	69%
b. Between easy and hard to get to	21%	28%	30%	19%	23%
c. Hard to get to	7%	6%	12%	7%	8%
7. Client needed care since enrolling in PPSP?	(n = 488)	(n = 41)	(n = 606)	(n = 349)	(n = 1484)
a. Yes	87%	73%	87%	94%	88%
b. No	13%	27%	13%	6%	12%
8. Client asked for referral to a specialist	(n = 492)	(n = 43)	(n = 608)	(n = 345)	(n = 1488)
a. Yes	37%	33%	35%	32%	35%
b. No	63%	67%	65%	68%	65%
c. Got referral from sponsor	66%*	28%*	81%*	80%*	74%*

*Percent based on those responding yes to question

	Phone/Mail (n = 495)	Assigned (n = 42)	District Office (n = 596)	Physician Office (n = 338)	Total (n = 1470)
9. Client asked for a second opinion					
a. Yes	12%	10%	13%	13%	12%
b. No	88%	90%	87%	87%	88%
c. Got help seeing another doctor	71%*	25%*	92%*	68%*	68%*
10. Client needed care during non-office hours	(n = 499)	(n = 42)	(n = 598)	(n = 338)	(n = 1477)
a. Yes	24%	14%	29%	21%	25%
b. No	76%	86%	71%	79%	75%
c. Did not know they could/called but no answer	37%*	34%*	16%*	25%*	26%*
d. Called and was told what to do	29%*	-	40%*	35%*	35%*
e. Waited until office opened	12%*	17%*	9%*	8%*	10%*
f. Went to emergency room	9%*	17%*	24%*	13%*	17%*
11. Needed emergency room care	(n = 498)	(n = 41)	(n = 600)	(n = 344)	(n = 1483)
a. Yes, and received care	23%	22%	29%	26%	26%
b. Yes, but did not get care	36%	49%	5%	3%	16%
c. No, did not need emergency room care	41%	29%	66%	72%	58%
12. Client's satisfaction with care before PPSP	(n = 487)	(n = 41)	(n = 261)	(n = 251)	(n = 1040)
a. Satisfied	88%	83%	78%	81%	84%
b. Somewhat satisfied	5%	5%	11%	9%	7%
c. Not satisfied	5%	12%	8%	6%	7%
13. Client's satisfaction with care under PPSP	(n = 480)	(n = 41)	(n = 255)	(n = 249)	(n = 1025)
a. Satisfied	74%	49%	61%	69%	69%
b. Somewhat satisfied	9%	17%	19%	14%	13%
c. Not satisfied	11%	22%	11%	10%	11%
14. Client's assessment of care under PPSP	(n = 12)	(n = 0)	(n = 340)	(n = 95)	(n = 447)
a. Better	33%	-	28%	25%	28%
b. Same	58%	-	53%	55%	53%
c. Worse	-	-	15%	14%	15%
15. Client's assessment of health status	(n = 12)	(n = 0)	(n = 331)	(n = 96)	(n = 439)
a. Excellent	-	-	14%	14%	13%
b. Good	42%	-	79%	73%	77%
c. Fair	25%	-	7%	13%	9%
d. Poor	33%	-	1%	-	1%

*Percent based on those responding yes to question

ANALYSIS BY DOCTOR RELATIONSHIP

PPSP MONITORING SURVEY RESULTS

Already Seeing Dr.Not Already Seeing Dr.

	(N = 1,195) (n = 1,177)	(N = 290) (n = 292)
1. How respondent enrolled in PPSP		
a. Client selected provider by phone	42%	4%
b. DSS assigned provider to client	1%	14%
c. Client enrolled through district office	36%	55%
d. Client enrolled through physician office	21%	27%
2. Client's relationship with sponsor doctor	(n = 1,195)	(n = 290)
a. Client was already seeing this doctor	100%	---
b. Client was not already seeing this doctor	---	100
3. Client's knowledge/readiness to choose a sponsor doctor	(n = 718)	(n = 138)
a. Client knew about options/was prepared to choose	88%	60%
b. Client did not know about options/was not prepared to choose	32%	39%
4. Was DSS information helpful?	(n = 744)	(n = 241)
a. Yes	62%	54%
b. No/Didn't receive it	30%	36%
c. Didn't read it	8%	11%
5. What client thought would happen if didn't choose a doctor	(n = 200)	(n = 79)
a. Would no longer get care/lose Medicaid coverage	45%	52%
b. DSS would select doctor/client asked to choose later	55%	49%
6. Access to doctor's office	(n = 807)	(n = 175)
a. Easy to get to	71%	62%
b. Between easy and hard to get to	22%	25%
c. Hard to get to	7%	14%
7. Client needed care since enrolling in PPSP?	(n = 1,158)	(n = 266)
a. Yes	90%	82%
b. No	10%	18%
8. Client asked for referral to a specialist	(n = 1,168)	(n = 262)
a. Yes	33%	41%
b. No	67%	59%
c. Got referral from sponsor	79%*	71%*

*Percent based on those responding yes to question.

	<u>Already Seeing Dr.</u> (n = 1,182)	<u>Not Already Seeing Dr.</u> (n = 273)
9. Client asked for a second opinion		
a. Yes	11%	20%
b. No	89%	80%
c. Got help seeing another doctor	83%*	73%*
10. Client needed care during non-office hours	(n = 1,164)	(n = 275)
a. Yes	23%	32%
b. No	77%	68%
c. Did not know they could/called but no answer	24%*	25%*
d. Called and was told what to do	42%*	21%*
e. Waited until office opened	11%*	9%*
f. Went to emergency room	14%*	22%*
11. Needed emergency room care	(n = 1,166)	(n = 279)
a. Yes, and received care	25%	30%
b. Yes, but did not get care	18%	19%
c. No, did not need emergency room care	60%	51%
12. Client's satisfaction with care before PPSP	(n = 828)	(n = 181)
a. Satisfied	87%	73%
b. Somewhat satisfied	8%	8%
c. Not satisfied	4%	14%
13. Client's satisfaction with care under PPSP	(n = 616)	(n = 177)
a. Satisfied	74%	52%
b. Somewhat satisfied	11%	19%
c. Not satisfied	9%	18%
14. Client's assessment of care under PPSP	(n = 339)	(n = 102)
a. Better	30%	22%
b. Same	50%	58%
c. Worse	18%	15%
15. Client's assessment of health status	(n = 337)	(n = 99)
a. Excellent	12%	20%
b. Good	83%	61%
c. Fair	4%	17%
d. Poor	1%	2%

*Percent based on those reporting yes to question.

ANALYSIS BY KNOWLEDGE/READINESS TO CHOOSE

PPSP MONITORING SURVEY RESULTS

Client knowledgeable/
Ready to Choose Dr.
(N = 599)
(n = 591)

Client not knowledgeable/
Not Ready to Choose Dr.
(N = 317)
(n = 310)

1. How respondent enrolled in PPSP		
a. Client selected provider by phone	7%	5%
b. DSS assigned provider to client	0%	0%
c. Client enrolled through district office	81%	54%
d. Client enrolled through physician office	31%	41%
2. Client's relationship with sponsor doctor	(n = 575)	(n = 281)
a. Client was already seeing this doctor	88%	80%
b. Client was not already seeing this doctor	14%	20%
3. Client's knowledge/readiness to choose a sponsor doctor	(n = 599)	(n = 317)
a. Client knew about options/was prepared to choose	85%	---
b. Client did not know about options/was not prepared to choose	---	35%
4. Was DSS information helpful?	(n = 303)	(n = 118)
a. Yes	72%	40%
b. No/Didn't receive it	27%	48%
c. Didn't read it	1%	13%
5. What client thought would happen if didn't choose a doctor	(n = 205)	(n = 94)
a. Would no longer get care/lose Medicaid coverage	74%	71%
b. DSS would select doctor/client asked to choose later	28%	29%
6. Access to doctor's office	(n = 286)	(n = 147)
a. Easy to get to	73%	64%
b. Between easy and hard to get to	21%	24%
c. Hard to get to	6%	12%
7. Client needed care since enrolling in PPSP?	(n = 593)	(n = 313)
a. Yes	92%	90%
b. No	8%	10%
8. Client asked for referral to a specialist	(n = 594)	(n = 313)
a. Yes	33%	33%
b. No	67%	67%
c. Got referral from sponsor	93%*	74%*

*Percent based on those responding yes to question

	Client Knowledgeable/ Ready to Choose Dr. (n = 563)	Client Not Knowledgeable/ Not Ready to Choose Dr. (n = 308)
9. Client asked for a second opinion		
a. Yes	10%	15%
b. No	90%	85%
c. Got help seeing another doctor	100%*	84%*
10. Client needed care during non-office hours	(n = 568)	(n = 309)
a. Yes	25%	28%
b. No	75%	74%
c. Did not know they could/called but no answer	20%*	18%*
d. Called and was told what to do	48%*	35%*
e. Waited until office opened	10%*	10%*
f. Went to emergency room	18%*	23%*
11. Needed emergency room care	(n = 591)	(n = 310)
a. Yes, and received care	27%	25%
b. Yes, but did not get care	1%	2%
c. No, did not need emergency room care	72%	74%
12. Client's satisfaction with care before PPSP	(n = 283)	(n = 140)
a. Satisfied	93%	64%
b. Somewhat satisfied	8%	21%
c. Not satisfied	1%	15%
13. Client's satisfaction with care under PPSP	(n = 291)	(n = 129)
a. Satisfied	81%	50%
b. Somewhat satisfied	11%	28%
c. Not satisfied	9%	25%
14. Client's assessment of care under PPSP	(n = 303)	(n = 158)
a. Better	28%	25%
b. Same	51%	56%
c. Worse	17%	11%
15. Client's assessment of health status	(n = 293)	(n = 159)
a. Excellent	18%	9%
b. Good	78%	78%
c. Fair	8%	11%
d. Poor	1%	3%

*Percent based on those responding yes to question

ANALYSIS BY SATISFACTION LEVEL

PPSP MONITORING SURVEY RESULTS

	<u>Satisfied</u> (N = 723) (n = 705)	<u>Somewhat Satisfied</u> (N = 129) (n = 133)	<u>Not Satisfied</u> (N = 118) (n = 114)
1. How respondent enrolled in PPSP			
a. Client selected provider by phone	51%	33%	45%
b. DSS assigned provider to client	3%	5%	8%
c. Client enrolled through district office	22%	38%	25%
d. Client enrolled through physician office	24%	26%	22%
2. Client's relationship with sponsor doctor	(n = 899)	(n = 120)	(n = 100)
a. Client was already seeing this doctor	87%	72%	70%
b. Client was not already seeing this doctor	13%	29%	30%
3. Client's knowledge/readiness to choose a sponsor doctor	(n = 299)	(n = 64)	(n = 42)
a. Client knew about options/was prepared to choose	78%	48%	24%
b. Client did not know about options/was not prepared to choose	21%	52%	76%
4. Was DSS information helpful?	(n = 371)	(n = 66)	(n = 85)
a. Yes	71%	27%	46%
b. No/Didn't receive it	21%	48%	33%
c. Didn't read it	8%	27%	20%
5. What client thought would happen if didn't choose a doctor	(n = 20)	(n = 18)	(n = 17)
a. Would no longer get care/lose Medicaid coverage	55%	39%	71%
b. DSS would select doctor/client asked to choose later	45%	61%	29%
6. Access to doctor's office	(n = 898)	(n = 130)	(n = 109)
a. Easy to get to	75%	52%	54%
b. Between easy and hard to get to	19%	32%	35%
c. Hard to get to	6%	15%	11%
7. Client needed care since enrolling in PPSP?	(n = 703)	(n = 137)	(n = 110)
a. Yes	93%	85%	91%
b. No	7%	15%	9%
8. Client asked for referral to a specialist	(n = 710)	(n = 138)	(n = 110)
a. Yes	33%	57%	47%
b. No	87%	43%	53%
c. Got referral from sponsor	76%*	40%*	44%*

*Percent based on those responding yes to question.

	<u>Satisfied</u> (n = 703)	<u>Somewhat Satisfied</u> (n = 134)	<u>Not Satisfied</u> (n = 112)
9. Client asked for a second opinion			
a. Yes	8%	28%	24%
b. No	92%	72%	76%
c. Got help seeing another doctor	87%	39%	30%
10. Client needed care during non-office hours	(n = 894)	(n = 129)	(n = 115)
a. Yes	22%	30%	38%
b. No	78%	70%	62%
c. Did not know they could/called but no answer	40%	26%	23%
d. Called and was told what to do	29%	23%	18%
e. Waited until office opened	8%	23%	9%
f. Went to emergency room	11%	10%	11%
11. Needed emergency room care	(n = 711)	(n = 135)	(n = 114)
a. Yes, and received care	24%	28%	37%
b. Yes, but did not get care	20%	28%	23%
c. No, did not need emergency room care	55%	46%	4%
12. Client's satisfaction with care before PPSP	(n = 719)	(n = 137)	(n = 113)
a. Satisfied	96%	57%	54%
b. Somewhat satisfied	2%	34%	9%
c. Not satisfied	1%	9%	37%
13. Client's satisfaction with care under PPSP	(n = 723)	(n = 129)	(n = 116)
a. Satisfied	100%	---	---
b. Somewhat satisfied	---	100%	---
c. Not satisfied	---	---	100%
14. Client's assessment of care under PPSP			
a. Better	---	---	---
b. Same	---	---	---
c. Worse	---	---	---
15. Client's assessment of health status			
a. Excellent	---	---	---
b. Good	---	---	---
c. Fair	---	---	---
d. Poor	---	---	---

*Percent based on those reporting yes to question.

COMMENTS FROM RECIPIENT SURVEYS

This Appendix is divided into two parts. The first lists complaints and concerns requiring follow-up and action by the Sponsor Specialist Unit Staff. The second lists comments by category which required no follow-up activity.

MY DAUGHTER FELL AND HURT HER KNEE BUT THE CLINIC WOULD NOT X-RAY HER BECAUSE THEY COULD NOT GET IN TOUCH WITH THE SPONSOR AND THEY WERE AFRAID OF GETTING STUCK WITH THE BILL IF THE DOCTOR DIDN'T OKAY IT. SHE HAD TO SUFFER UNTIL THE NEXT DAY WHEN OUR SPONSOR COULD SEND HER FOR X-RAYS. MY DOCTOR WAS VERY UPSET AND I WILL NEVER GO TO THAT CLINIC AGAIN.

Client states that her problem was with the clinic and not with her sponsor. Sponsor Specialist Worker called the clinic and got a recording which stated that the office was closed and would be open the following day. A message was left and a doctor would get back in touch with the caller when possible. This is not in compliance with the contract. Letter mailed to doctor regarding proper 24-hour coverage.

I WOULD LIKE IT CANCELLED IN CASE HE DOES DEVELOP PROBLEMS WHERE HE MAY HAVE TO BE REFERRED TO A SPECIALIST SINCE HE DOES HAVE A HEART CONDITION.

Client currently in hospital. Sponsor Specialist worker left message at clients home if client has questions or problems.

I WASN'T TOLD ABOUT THIS PLAN. I DIDN'T PICK THIS DOCTOR AND I HAVEN'T BEEN BACK TO SEE HIM SINCE THE BABY WAS BORN BECAUSE I DON'T LIKE THIS DOCTOR. I NEVER WANT TO GO BACK BECAUSE OF THE POOR WORK THIS DOCTOR DID. I DON'T KNOW WHY THEY GAVE ME THAT DOCTOR. I PREFER MY OWN DOCTOR. THIS DOCTOR DOES POOR WORK AND GIVES NO CONSIDERATION.

Client has called in for a change of sponsor. Problem was with her former sponsor.

I THINK IT'S A PROBLEM WHEN YOU HAVE TO CONTACT YOUR SPONSOR DOCTOR TO GO TO THE DENTIST OR YOUR GYNECOLOGIST.

Client contacted by telephone and indicated no specific problem, just needed information. Booklet on three plans mailed to the client.

MY SPONSOR DOCTOR IS ON STAFF AT ONE HOSPITAL BUT THERE ARE TWO OTHER HOSPITALS CLOSER TO MY HOME. I WOULD LIKE TO BE ABLE TO GO TO THE CLOSEST EMERGENCY ROOM IF THE NEED ARISES. ALSO, NOBODY EVER TOLD ME THAT MEDICAID QUIT PAYING FOR WELL BABY CARE AND FOR BABY SHOTS. NOW I HAVE A \$129.00 BILL THAT I CAN'T PAY.

Client has no telephone. She was mailed a booklet and a letter asking her to contact the sponsor specialist staff if she had questions.

I TOOK MY SON TO THE EMERGENCY ROOM BUT MEDICAID DIDN'T PAY. THEY SAY IT WASN'T AN EMERGENCY. NOW I MUST PAY \$61.65.

Client was advised to file for a fair hearing. Worker at Sponsor Specialist Unit explained how to do this to client.

MY SON SOMETIMES NEEDS SHOTS TO HELP HIM BREATHE AND THESE SHOTS AREN'T COVERED AT HIS ASTHMA SPECIALIST NOR WILL THE HOSPITAL ANY LONGER GIVE THEM TO HIM. THEY DID A COUPLE OF YEARS AGO, BUT WON'T ANY LONGER. BECAUSE OF THIS MY SON GETS WORSE INSTEAD OF BETTER.

ALSO THERE ARE SPECIFIC MEDICATIONS HE HAS TO HAVE FOR HIS ASTHMA AND THEY AREN'T COVERED. THIS WILL ONLY COST MEDICAID MORE IN THE LONG RUN SINCE HE STAYS SICK LONGER AND HAS TO KEEP GOING BACK TO DOCTORS, SPECIALISTS AND HOSPITALS.

MY SON WAS HURT LAST YEAR IN SCHOOL AND NEEDS FURTHER TESTS FOR HIS HEAD BECAUSE OF PERISTANT SEVERE HEADACHES. HIS DOCTOR IS DOING NOTHING FOR THIS. I BELIEVE HIS DOCTOR IS NOT GIVING HIM PROPER TREATMENT. NOW I MUST SEARCH FOR ANOTHER DOCTOR THAT WILL TAKE MEDICAID.

ALSO, THERE WAS A TIME I NEEDED TO CALL A CLINIC WHEN I PULLED MY BACK OUT. IT WAS A FRIDAY EVENING AND MY DOCTOR WAS CLOSED AND THE CLINIC REFUSED TO TREAT ME BECAUSE OF MY SPONSOR PLAN. I STAYED IN PAIN FOR THREE DAYS UNTIL MY DOCTOR COULD SEE ME. MY BACK HASN'T BEEN RIGHT SINCE.

I DON'T FEEL MY SON AND I ARE GETTING PROPER MEDICAL CARE. BUT I HEAR OTHER PLANS ARE WORSE BECAUSE YOU HAVE DIFFERENT DOCTORS CHECKING YOU EACH TIME. I DID HAVE BETTER MEDICAL TREATMENT FOR MYSELF AND MY SON BEFORE ANY OF THIS STARTED.

Sponsor Specialist worker encouraged the client to appeal for non-payment of shots. Client was a bit resistant to this but said she would talk with her social worker. Client was also urged to ask her doctor for a second opinion referral regarding her back. Sponsor Specialist worker also told client to call back if she has any other problems.

I DON'T LIKE MY DOCTOR. I GOT HIT IN THE HEAD WITH A BOTTLE AND I HAVE HAD SEVERE HEADACHES. MY DOCTOR REFUSED TO REFER ME TO A SPECIALIST AND THE PROBLEMS SEEMS TO BE GETTING NO BETTER.

Sponsor Specialist worker spoke with clients husband who stated they had the problem with the bottle before enrolling in the Sponsor Plan. His wife sought treatment in an emergency room. He said they have no problems with the Sponsor Plan or their doctor.

I SIGNED UP FOR THIS WITH MY WORKER AND PUT MY DOCTOR'S NAME DOWN. WHEN MY MEDICAID CARD CAME IT HAD A STRANGE DOCTOR'S NAME ON IT.

Client called Sponsor Specialist Unit and now has her own doctor on the card.

I FELL AND HURT MY ARM AFTER MIDNIGHT. THE NEXT DAY I CALLED MY CLINIC AND THEY WERE CLOSED SO I WENT TO THE HOSPITAL EMERGENCY ROOM AND WAITED FROM 10:00 a.m.- 4:00 p.m. BEFORE THEY SAW ME. THEY TOOK X-RAYS AND GAVE ME SOME PAIN PILLS AND TOLD ME TO CALL MY DOCTOR. I CALLED MY DOCTOR THE NEXT DAY AND THEY TOLD ME HE WAS OUT OF TOWN. I ASKED WHO WAS COVERING FOR HIM AND THEY GAVE ME A DOCTORS NUMBER TO CALL. THE PHONE JUST RANG AND RANG AND NO ONE ANSWERED. I KEPT CALLING BACK BACK FINALLY SOMEONE DID ANSWER. IT WAS A WOMAN AND SHE TOLD ME TO KEEP MY LINE OPEN AND A DOCTOR WOULD CALL

ME BACK. I HAVE NO TELEPHONE BUT MY LANDLADY LET ME USE HER PHONE. WE BOTH WAITED UNTIL MIDNIGHT. NO ONE CALLED BACK. FINALLY MY LANDLADY TOOK ME TO ANOTHER HOSPITAL AND A DOCTOR TOOK CARE OF ME. MY ARM IS STILL NOT WELL. THIS DOCTOR ALSO TOLD ME TO CALL MY OWN DOCTOR. I CALLED 4 TIMES AND MY DOCTOR NEVER SPOKE TO ME, JUST THE RECEPTIONIST TALKED TO ME. SHE SAID THAT THE DOCTOR HAD CALLED IN A PRESCRIPTION FOR ME. I WAS IN SUCH PAIN I COULDN'T EVEN DRESS MYSELF TO GO GET IT. FINALLY I WENT TO THE DOCTORS OFFICE. MY DOCTOR DID NOT SEEM CONCERNED ABOUT MY ARM BUT SAID SHE WOULD SEND A THERAPIST OUT TO SEE ME. THIS TOOK 10 DAYS. AT ANOTHER TIME WHEN I NEEDED SOME WORK DONE ON MY FEET THE DOCTOR SENT ME TO AN ORTHOPEDIC DOCTOR AT THE HOSPITAL. HE SAID HE COULD FIX MY FOOT, BUT THEN I NEVER HEARD ANYTHING BACK FROM THEM AT ALL. MY DOCTOR ALSO SENT ME TO ANOTHER SPECIALIST, THIS TIME AN OPHTHALMOLOGIST. I HAVE CATARACTS ON BOTH OF MY EYES. THE OPHTHALMOLOGIST PUT DROPS IN MY EYES AND GAVE ME A TEST, AND THAT WAS THAT. I HAVEN'T HEARD BACK FROM THEM FOR MORE THAN TWO MONTHS. ALSO, SINCE I'M TELLING YOU ABOUT THIS, IF YOU GO TO SEE MY SPONSOR DOCTOR, IF YOU HAVE AN APPOINTMENT AT 8:30 a.m. YOU HAVE TO WAIT AT LEAST 2 HOURS TO SEE THE DOCTOR. WHY BOTHER EVEN MAKING AN APPOINTMENT! THEY JUST RUSH YOU THROUGH LIKE YOU WERE A BUNCH OF ANIMALS. COULD YOU PLEASE SEND ME SOME INFORMATION ABOUT WHY WHEN YOU GET ON MEDICAID YOU HAVE TO DEPOSIT \$75.00 WITH THE CLINIC? ALSO, IN MY OPINION ALL THE TESTS THEY WANT TO TAKE ARE A WASTE OF MONEY. I'M SORRY I HAVE WRITTEN SO MUCH, BUT YOU ASKED AND I HAD TO EXPLAIN.

Sponsor Specialist worker contacted the client. She stated there was no problem with her sponsor although she did not like the wait at the clinic. Sponsor is in compliance with 24 hour access provision of contract. The \$75.00 deposit was a misunderstanding of a sign posted in the clinic regarding the Medicare deductible. Client states that signs have been removed because many patients were confused by them.

WHEN I WENT TO THE CLINIC THEY GAVE ME A PAPER AND I ASKED THEM IF I COULD WAIT AND THINK ABOUT IT FOR A WHILE. THEY SIGNED ME IN THERE ANYWAY. I WOULD LIKE TO CHANGE FROM THE CLINIC TO MY FAMILY DOCTOR.

Client has no telephone, Sponsor Specialist worker mailed her a booklet and letter asking her to contact them.

LAST SUMMER WHEN I CALLED THEY COULDN'T LOCATE THE DOCTOR. ALSO, I CAN'T UNDERSTAND MY DOCTOR. HE IS NOT TREATING MY CHILD'S ULCER AND SAYS THAT SHE IS FAKING WHEN SHE COMES IN FOR CARE.

There is a language barrier between client and doctor. This doctor was recommended by a friend but the client could not communicate with him and has requested a change of sponsor.

I HAVE FILLED OUT FORMS SINCE APRIL TO HAVE A SPONSOR PUT ON MY CARD BUT IT HASN'T GONE THROUGH YET. THE KIDS HAVE NAMES ON THEIR CARD BUT I DON'T AS OF YET. I WOULD LIKE US TO GO TO THE SAME PLACE.

Client wants to change doctors but does not know of another doctor where she would go for care. She will call back as soon as she finds one.

I DON'T WANT MY DAUGHTER ON THE SPONSOR PLAN BECAUSE IT IS NOT WORKING OUT. SHE DIDN'T GET TO SEE A SPECIALIST BECAUSE SHE WAS SIGNED UP WITH THE SPONSOR DOCTOR. I WANT HER OFF THE SPONSOR PLAN.

Client upset because she can't go to any doctor she wants to. Took child to doctor other than the sponsor and the doctor's office refused to see the child or call the sponsor for authorization. Adamant about taking client off the sponsor plan. Unhappy when worker refused to do so. Explained PPSP to client. Still very dissatisfied.

MY CHILD HAD STOMACH CRAMPS AND MY DOCTOR WAS IN A HURRY TO GET HOME. SHE DIDN'T EXAMINE MY DAUGHTER VERY WELL AND JUST PRESSED ON HER STOMACH AND SAID SHE HAD A URINARY TRACT INFECTION. THE DOCTOR DIDN'T EVEN WRITE A PRESCRIPTION. MY CHILD WAS STILL IN PAIN SO I TOOK HER TO THE HOSPITAL EMERGENCY ROOM. THEY SAID SHE HAD A COLD IN HER STOMACH AND GAVE A PRESCRIPTION. THIS WAS THE SECOND TIME I'VE HAD DIFFICULTY WITH THIS DOCTOR. THE FIRST TIME MY CHILD HAD BURNS AND THE HOSPITAL COULDN'T LOCATE THIS SPONSOR.

Very unhappy with doctors mannerisms, and seeming lack of concern.
Changed doctors.

WHEN I GO TO THE DRUGSTORE OR TO OTHER DOCTORS THEY ALWAYS SAY THEY HAVE TO CHECK WITH MY SPONSOR OR CALL HIS OFFICE BEFORE SEEING ME OR WAITING ON ME. I THINK IT SHOULD BE BETTER, FOR THE HEALTH OF THEIR PATIENTS AND CUSTOMERS.

Client has no phone, letter and booklet sent.

I DON'T LIKE JUST HAVING ONE DOCTOR I CAN SEE. I WENT TO SEE A SPECIALIST AND DIDN'T KNOW I HAD TO GET AN OKAY FROM MY DOCTOR. I COULDN'T GET A HOLD OF HIM SO I HAD TO CANCEL AND RE-SCHEDULE.

Client claims she never had a complaint or a problem of any kind.

I WOULD LIKE TO CHANGE DOCTORS AS SOON AS I CAN BECAUSE HE CAN'T HELP ME WITH THE PROBLEMS THAT I'M HAVING.

Client in recipient monitoring since 6-1-84, enrolled in PPSP 9-1-85, and is currently in both programs in error. Disenrolled.
Letter and booklet mailed to client 24-hour check done on telephone and doctor does have an answering service.

THE BABY'S DOCTOR IS ONLY IN HIS CLINIC OFFICE ON THURSDAY. MY BABY WAS REAL SICK AND I COULD NOT GET IN TOUCH WITH HIM AT ANY OF THE FOUR NUMBERS ON THE CARD THAT HE GAVE ME. FINALLY I TOOK THE BABY TO THE HOSPITAL EMERGENCY ROOM. I WISH HE COULD HAVE HAD A 24-HOUR ANSWERING SERVICE THAT WAS WORKING. THE ONE THAT WAS ON MY MEDICAID CARD WAS NOT WORKING.

Client says she now knows where to reach the doctor and there is no longer any problem.

I HAVE DIFFICULTY SEEING MY DOCTOR BECAUSE HE IS IN A CLINIC AND I WASN'T ALLOWED TO PUT THE CLINIC DOWN AS MY SPONSOR. MY SON HAS HIS OWN DOCTOR BUT MY DOCTOR USED TO TREAT HIM WHEN WE WERE BOTH SICK OR IF HIS DOCTOR'S OFFICE WAS CLOSED. WE CAN NO LONGER DO THAT UNDER THE SPONSOR PLAN. I DO NOT LIKE HAVING TO WAIT IN AN EMERGENCY FOR MY DOCTOR'S AUTHORIZATION BEFORE WE CAN BE TREATED. MY SON'S ASTHMATIC AND I DON'T ALWAYS HAVE THE TIME TO WAIT FOR AN AUTHORIZATION.

Client contacted by phone, letter and booklet was sent. Issue resolved.

I DON'T LIKE THE FACT THAT I CAN'T GO TO MY GYNOCOLOGIST. I WAS TOLD I HAD TO SEE MY FAMILY DOCTOR INSTEAD. I DON'T WANT TO SEE MY FAMILY DOCTOR FOR MY FEMALE PROBLEMS. I TRUST MY GYNOCOLOGIST BUT NOW I CAN'T SEE HIM BECAUSE IT ISN'T PERMITTED. WHY IS THIS? I TRUST MY REGULAR DOCTOR IN EVERYTHING, BUT I FEEL MORE AT EASE AND MORE CONTENT WITH MY GYNOCOLOGIST FOR MATTERS OF A PERSONAL NATURE.

Worker called three times client not home sent letter and booklet.

SINCE I JOINED THIS PLAN, MY DOCTOR DOES NOT SEEM TO HAVE AS MUCH TIME TO ANSWER MY QUESTIONS OR GIVE ME MY TEST RESULTS. I HAD TO CALL HIM FOR THREE WEEKS IN ORDER TO RECEIVE RESULTS AND HAVE A PRESCRIPTION WRITTEN FOR MY PROBLEM. I'VE NEARLY STOPPED GOING TO THE DOCTOR EVEN THOUGH I KNOW I SHOULD FOR THIS REASON. I THINK HE SHOULD HAVE RETURNED MY CALLS BECAUSE I SHOULD HAVE BEEN ON MEDICATION FOR THOSE THREE WEEKS I WAS TRYING TO CONTACT HIM.

Client has no telephone. Letter and booklet sent.

A DOCTOR WAS CHOSEN FOR ME WHOM I DID NOT WANT. I'VE SENT IN TWO CHANGE FORMS ALREADY BUT NOTHING HAS HAPPENED YET. I WILL CALL NOW THAT I KNOW THERE IS A PLACE TO TALK TO SOMEONE.

Client has no phone letter and booklet sent.

I COULDN'T GET MOST OF MY PRESCRIPTIONS FILLED. I CHANGED TO ANOTHER PHARMACY.

Client's problem resolved, prescriptions were non-Medicaid covered services. She will stick to one pharmacy though just in case there are other problems. 24-hour access also explained.

I NEEDED TO SEE MY GYNECOLOGIST BUT I WAS AFRAID TO ASK MY DOCTOR BECAUSE HE WOULDN'T SEND ME TO THE DOCTOR I'VE BEEN GOING TO. I ALSO WENT TO THE PHARMACY AND THEY REFUSED TO FILL MY PRESCRIPTION BECAUSE THE SPONSORS NAME WASN'T ON IT, ANOTHER DOCTOR WHO WORKS OUT OF THE SAME HOSPITAL WAS ON IT.

Client didn't understand program, booklet and letter sent. She will go to another pharmacy. She has an unpaid bill because no referral was ever made. She will call back regarding that. Pharmacy was contacted and program explained to worker there.

AM I ALWAYS LIMITED TO GO OR TAKE MY CHILDREN TO THE MEDICAID SPONSORED DOCTOR? WHAT HAPPENS IF THESE PHYSICIANS ARE UNABLE OR SHOULD MOVE AWAY?

Telephone disconnected letter and booklet sent to client.

I'VE HAD PROBLEMS GETTING CARE SINCE JOINING THE MEDICAID SPONSOR PLAN. I AM VERY UNHAPPY ABOUT IT. HAD I KNOWN AT THE TIME THAT JOINING THE SPONSOR PROGRAM WOULD CAUSE ME SO MUCH TROUBLE I WOULD NOT HAVE JOINED. THE ONLY REASON I DID JOIN WAS BECAUSE I WAS TOLD I WOULD LOSE MY MEDICAID CARD IF I DID NOT. IF THERE IS ANY WAY POSSIBLE FOR ME TO DROP THE SPONSOR I MOST SURELY WILL. IF YOU COULD SEND ME ANY INFORMATION ON THIS PROBLEM IT WOULD CERTAINLY HELP.

Client has no telephone. Booklet and letter mailed to her.

I SIGNED UP FOR A DOCTOR BUT INSTEAD WAS ASSIGNED TO A PEDIATRICIAN WHO DID NOT WANT TO TREAT MY NIECE, BUT DID. THIS DOCTOR WOULD NOT GIVE CONSENT FOR HER TO SEE THE DOCTOR I HAD CHOSEN. IT THEN TOOK SIX WEEKS FOR THE CARD TO HAVE THE NAME OF THE REQUESTED DOCTOR ON THE CARD.

Previous problem regarding change of sponsor has been resolved.
No current problems. Advised her to call if any PPSP problems arise.

I DON'T UNDERSTAND FULLY HOW THESE PLANS WORK. DO YOU CALL THE SPONSOR DOCTOR EACH TIME YOU HAVE TO BE REFERRED TO A DOCTOR SUCH AS A SPECIALIST FOR INSTANCE? WE SHOULD HAVE A LIST OF SPONSOR DOCTOR'S HOMES. I HAD TO LOOK UP IN A PHONE BOOK AND CALL AROUND UNTIL I FOUND MY SPONSORS HOME NUMBER.

No particular problem. Just doesn't like the idea of needing a referral to see her ob/gyn and skin doctors.

I DON'T KNOW IF MY DOCTOR IS GOING TO BE PAID, BUT I HAD TO GO TO HIM BECAUSE I HAD SEVERE HEADACHES AND I HAD NERVE DAMAGE DONE TO MY HEAD. I KNOW SOME DOCTORS OVERCHARGE ON THE INSURANCE, BUT HOW CAN I SAY ANYTHING ABOUT IT WITHOUT GETTING INTO SOME PROBLEMS. I KNOW ONE OF MY DOCTORS CHARGED FOR BLOOD TESTING DONE ON BOTH GIRLS WHEN ONLY ONE GIRL WAS CHECKED. IT BOTHERED ME BUT I DON'T KNOW WHAT TO DO ABOUT IT.

Client has no telephone. Letter sent asking her to contact Sponsor Specialist Worker.

I AM A VERY SICKLY PERSON BUT I CAN ONLY SEE MY DOCTOR ON THURSDAY. I HAVE HIGH BLOOD PRESSURE AND ARTHRITIS IN MY SPINE AND MOST EVERYWHERE ELSE TOO.

Client has no telephone. She was mailed a copy of the three plan booklet and a letter asking her to call the Sponsor Specialist Unit if needed.

I WENT TO A PHARMACY AND THEY REFUSED TO FILL MY PRESCRIPTION BECAUSE THE DOCTOR ON THE CARD WAS DIFFERENT THAN THE DOCTOR ON THE PRESCRIPTION, EVEN IF BOTH OF THESE DOCTORS WORK AT THE SAME HOSPITAL, AND ONE SENT ME TO THE OTHER.

Client did not understand the program very well so a booklet was mailed to her. Client states she will go to another pharmacy and doesn't mind doing so. Pharmacy contacted and program explained.

THEY DON'T WANT YOUR MEDICAID CARD, THEY WANT YOUR MEDICARE CARD. I HAVE REFUSED A LOT OF TESTS BECAUSE I DON'T THINK ARE NECESSARY. I SEE NO REASON TO RUN UP A BIG BILL AND TO MAKE A LOT OF APPOINTMENTS. THEY JUST PUT FIVE PATIENTS IN THE EXAMINING ROOMS AND RUN YOU THROUGH LIKE A BUNCH OF CATTLE. I DON'T FEEL I'M ANY BETTER THAN ANYONE ELSE BUT I DO THINK I SHOULD BE TREATED LIKE A HUMAN BEING. WE ALL HUMAN AND I TRY TO TREAT EVERYONE LIKE I LIKE TO BE TREATED MYSELF. I COULD TALK TO YOU FOR HOURS ABOUT THIS BUT THE CLINICS WILL RUN THE WAY THEY ARE RUN NOW ANYWAY. I HOPE THIS INFORMATION HELPS YOU A LITTLE BIT. I HOPE WITH YOUR JOB YOU CAN START LOOKING INTO WHAT HAPPENS IN CLINICS IF YOU ARE ABLE.

Client has no telephone. Letter and booklet sent.

I DON'T LIKE THIS NEW PLAN. IT IS DIFFICULT FOR ME TO SEE A DERMATOLOGIST EVERY OTHER WEEK FOR A SKIN CONDITION THAT I HAVE HAD FOR A WHILE. I HAVE BEEN TOLD THAT THIS TREATMENT MAY GO ON INDEFINITELY AND I MUST KEEP GETTING PERMISSION FROM MY SPONSOR. CAN'T THEY PUT MY DERMATOLOGISTS NAME ON MY CARD?

Client is participating voluntarily in PPSP as he is active Medicare. Telephone number has been changed to an unpublished number. Letter and booklet sent to this client.

HAVING ONE DOCTOR CAN BE A PROBLEM WHEN YOU CAN'T GET IN TOUCH WITH HIM MOST OF THE TIME. THE DOCTOR I PICKED FOR MY CHILDREN IS HARDLY EVER IN, ONLY TWICE A WEEK. WHAT DO I DO FOR THE OTHER DAYS AS I HAVE FOUND MYSELF MORE THAN ONCE AND HAD TO PAY FOR ANOTHER DOCTOR TO TREAT MY CHILDREN. I DON'T LIKE IT. THIS IS TOO RESTRICTIVE.

Client called Sponsor Specialist Unit to change his children's sponsor. Sponsor has taped message which directs caller to his answering service if it is an emergency. This appears to meet the requirements for 24-hour coverage.

THE ONLY THING I WANT TO SAY IS I THINK ITS WRONG THAT YOU NEED TO CALL YOUR DOCTOR WHEN YOU GO TO THE EMERGENCY ROOM. I HURT MY BACK AND I WAS IN A LOT OF PAIN. I HAD TO STAND AT A PAY PHONE AT THE HOSPITAL TO GET A HOLD OF MY DOCTOR ON NEW YEAR'S EVE BEFORE I COULD BE TREATED. THIS IS WRONG. I FEEL THAT IF IT'S AN EMERGENCY YOU SHOULDN'T NEED THE OKAY FROM THE DOCTOR FOR MEDICAID TO PAY IT. IT WOULDN'T BE AN EMERGENCY IF YOU COULD WAIT UNTIL MORNING TO SEE YOUR DOCTOR.

After the client's emergency room experience her doctor explained the emergency room policy to her. The client has no other problems. She was asked to call the Sponsor Specialist worker if she has further problems or questions.

I HAVE BEEN SEEING MY SPONSOR DOCTOR FOR SOME YEARS. I ALSO SEE A NEUROLOGIST AND TWO OTHER SPECIALIST FOR CANCER. THEY ARE NOT UNDER THE SPONSOR PLAN. MY SON ALSO HAS A SPONSOR AND SEES TWO SPECIALISTS ONE FOR HYPERACTIVITY AND ONE FOR PSORIASIS. NEITHER OF THESE TWO DOCTORS ARE REFERRALS FROM OUR SPONSOR. I DON'T MISUSE OUR INSURANCE, BUT BY THE SAME TOKEN IT TAKES A GREAT TOLL ON OUR FINANCES FOR THE SPECIALIST. THIS IS IN ADDITION TO THE MENTAL STRAIN OF HAVING TO WORRY ABOUT OUR FAMILY. I REALIZE THE MISUSE HAS TO BE CHECKED, BUT I FEEL THAT SOME OTHER WAY MUST BE FOUND.

Client has no phone. Letter and booklet sent asking client to call.

MY DOCTOR IS ONLY THERE ON THURSDAY AND IT COSTS ME \$4.00 CAB FEE IF I GO TO SEE HIM. HE HAS ANOTHER OFFICE BUT I CAN'T AFFORD TO GET OUT THERE.

Client has already changed providers. Change should resolve complaint.

MY WIFE HAD A REACTION FROM HER PILLS SO I CALLED THE DOCTOR BUT NO ONE ANSWERED. WE WAITED UNTIL THE NEXT DAY TO GET A HOLD OF HER. I'M NOT SATISFIED. THE DOCTOR WE JOINED WITH DID NOT GET MY MEDICAL RECORDS FROM MY OTHER DOCTOR. WHEN I TOLD HER ABOUT MY HEALTH SHE DID NOT CARE OR ACTED LIKE SHE DID NOT BELIEVE ME. NOW WE DO NOT KNOW WHERE SHE IS. WE WERE TOLD SHE GOT KICKED OUT OF THE OFFICE BY THE OWNER. WHAT I WOULD LIKE TO KNOW IS IF WE CAN GET OUT OF THE SPONSOR PLAN. WE ARE LOOKING FOR A DOCTOR ON THE PLAN BUT THE PEOPLE WHO WE TALK TO ABOUT IT SAY THEY DON'T LIKE THEIR DOCTORS BUT ONLY GO TO THEM BECAUSE THEIR OFFICE IS HERE IN HAMTRAMCK.

Client has changed doctors as indicated on VDT. The telephone has been disconnected so Sponsor Specialist worker could not check with client to see if there is any problem.

WE WERE SEEING A DOCTOR BUT WE WERE TOLD SHE HAS BEEN DISMISSED AND WE'RE SUPPOSED TO SEE ANOTHER DOCTOR. WE HAVEN'T AS YET SEEN HIM SO I CANNOT COMMENT ON HIS SERVICES.

Client was enrolled with a doctor who moved her office across the street from her old location. The client may remain with this Sponsor or with the doctor at her previous location. Client has no telephone so letter and booklet sent.

I WENT TO THE EMERGENCY ROOM AND GOT CARE BUT LATER THEY SAID THEY WOULD NOT PAY BECAUSE IT WAS NOT AN EMERGENCY. THEY KEEP SENDING ME HARRASING LETTERS SAYING THAT MEDICAID WON'T PAY AND I HAVE TO BECAUSE OUR SITUATION WAS NOT LIFE THREATENING.

Client has no telephone. Letter and booklet sent to the client.

I STILL DO NOT KNOW ANYTHING ABOUT THE HMO OR CLINIC PLAN. I DON'T HAVE A CLEAR UNDERSTANDING. IT WAS UNDERSTOOD THAT I MAY IF AT ANYTIME THE SPONSORED DOCTORS OFFICE IS CLOSED, GO TO EMERGENCY. AM I NOT RIGHT?

Client has no telephone. Booklet and letter asking client to contact Sponsor Specialist worker mailed to client.

I WOULD LIKE TO KNOW IF THERE WAS AN EMERGENCY WOULD I BE ABLE TO GO TO A 24 HOUR EMERGENCY CLINIC?

Letter and booklet sent to the client.

I WOULD LIKE TO CHANGE MY SPONSOR TO ONE AT ANOTHER HOSPITAL. I WOULD ALSO LIKE TO TALK TO SOMEONE ABOUT A BILL I OWE BECAUSE I WENT TO A DOCTOR WITHOUT MY SPONSORS PERMISSION. I DID THIS ONLY BECAUSE I FELT AT THE TIME THAT IT WAS AN EMERGENCY.

Client is voluntarily participating in PPSP according to her program code. Client has no telephone so contact could not be made. She recently changed her sponsor.

A MEMBER OF THE GROUP REQUIRED IMMEDIATE ATTENTION. HE COULDN'T BREATHE. HE WAS RUSHED TO THE EMERGENCY ROOM AT THE HOSPITAL. IN CASE OF EMERGENCY I FEEL THE IMMEDIATE ATTENTION IN THE HOSPITAL IS THE BEST TREATMENT.

This is an AFC facility. Sponsor Specialist worker attempted to call six times at different hours of the day. Telephone was either busy or unanswered.

I AM CONSIDERING CHANGING A SPONSOR DUE TO A LONG WAIT IN THE OFFICE. IT CAN BE AS LONG AS A TWO HOUR WAIT, AND WE WERE ON TIME FOR OUR APPOINTMENT. ALSO, I WENT TO A THYROID SPECIALIST BECAUSE I FELT I COULD BE TREATED BETTER BECAUSE THE DOCTOR WOULD BE MORE QUALIFIED. WHEN THEY CALLED TO GET THE ID NUMBER FROM MY SPONSOR DOCTOR, THE NURSE REFUSED TO GIVE IT TO THEM. I CALLED THE MEDICAID SPONSOR OFFICE AND THEY SAID IT WAS MY RIGHT TO BE SEEN BY A SECOND DOCTOR. AFTER TWO HOURS OF CALLING AND TALKING TO FOUR PEOPLE, MY FATHER FINALLY WAS ABLE TO HAVE THEM APPROVE IT.

Sponsor Specialist worker attempted to make contact with this client by phone but received no answer. After five tries the worker mailed the client a letter asking her to call the unit if there were problems and a booklet.

MY DOCTOR SAID THAT THE PROBLEM I WAS HAVING WITH MY NOSE AND THROAT SHOULD BE TREATED BY A SPECIALIST. HE ASKED ME IF I KNEW ONE BUT I DIDN'T, SO THE NURSE GAVE ME A NAME. I WAS REFERRED TO A DOCTOR WHO SAID I NEEDED AN OPERATION. I HAD THE SURGERY BUT IT DIDN'T DO ME ANY GOOD. I KNOW NOW THAT I CAN SEE ANOTHER DOCTOR FOR SECOND OPINION AND I WILL DO JUST THAT. THE DOCTORS AT MY CLINIC ARE GOOD, BUT PICKING A SPONSOR I THINK IS NOT SUCH A GOOD IDEA. WHEN YOU TAKE SICK AT NIGHT OR SOMETHING AND HAVE TO GO TO EMERGENCY IT MAKES IT VERY HARD TO GET WAITED ON. WHEN I WAS SUFFERING CHEST PAINS AND CALLED EMS, THEY TOOK ME TO THE HOSPITAL AND I HAD TO WAIT FOUR HOURS AFTER THEY SAW I HAD A SPONSOR DOCTOR ON MY CARD. NOW, YOU TELL ME, DO YOU THINK IT'S SUCH A GOOD IDEA TO HAVE A SPONSORS NAME ON THE CARD?

Client mailed a booklet and note from Sponsor Specialist worker addressing problems of emergency room usage, referrals and coercions (based on response to questionnaire).

I GOT THE FEELING THAT BECAUSE I WAS ON MEDICAID AND ALREADY HAD A LITTLE DAUGHTER THAT THE DOCTOR THINKS IT'S HIS RESPONSIBILITY TO USE METHODS TO CONTROL THE POPULATION. I WAS TOLD BY A SURGEON THAT I MIGHT HAVE UTERINE INFECTION. HE TOLD ME IF I DID, I HAD TWO OPTIONS: (1) TO GET BACK ON THE PILL OR (2) TO HAVE A HYSTERECTOMY, IF THE PILL WAS NOT LOGICAL. IF I COULD USE THE PILL TO STOP MY PROBLEM, WHY WOULD A HYSTERECTOMY BE NECESSARY?

Sponsor Specialist worker contacted client by telephone. Client states she has irregular periods and the doctor suggested birth control to regulate them. She is 21 years old and was frightened when the doctor suggested the possibility of a hysterectomy before he reviewed her lab results. Sponsor Specialist worker explained there was not much that could be done except to keep the name of the specialist on file for the possibility of complaints against him in the future. Client also indicated some pressure to enroll in PPSP on the part of her case worker in her questionnaire response. She stated she was told she would be assigned to a sponsor. This was referred to project director in Lansing for follow-up to district office.

I SIGNED UP FOR WIC AT THE HEALTH DEPARTMENT OFFICE. A DOCTOR THERE WAS CHOSEN FOR ME. I HAVEN'T BEEN TO THE DOCTOR SINCE THE NAME HAS BEEN ON MY CARD.

Client claims she was enrolled with a doctor at a clinic but does not know how. The client claims it is no problem for her. Form was forwarded to request to see if client requested doctor at the clinic. Client is not enrolled for health care with the health department, but this will not effect her receiving WIC.

I AM NO LONGER WITH HIM. THEY CAN'T TELL ME WHY I KEEP LOSING MY BABIES. I DON'T WANT NO SPONSOR. LEAVE MY CARD LIKE IT WAS.

Client has no telephone. She was mailed a copy of the three plan booklet and a letter asking her to contact the Sponsor Specialist worker to further explain her problem and possible action to help her.

I WOULD LIKE TO CHANGE OVER TO ANOTHER DOCTOR OR CLINIC THAT IS EASY TO GET TO AND BETTER STAFFED.

Sponsor Speicalist worker spoke with client on the phone. She wishes to change doctors and is thinking about signing up with one of the larger clinics. Sponsor Specialist worker advised client to contact specific sponsor. Also gave her 256-9344 number that she could call if she wanted to make a change in the future.

I CAN'T SEE NO OTHER DOCTOR BECAUSE THEY HAVE MY GYNCOLOGIST ON THE CARD. IT'S A BIG PROBLEM AND I CAN'T GET NO KIND OF PAIN PILLS AND I NEED SOME FOR MY BACK. THE MEDICAID IS NOT RIGHT. YOU CAN TAKE THE NAME ON THERE OFF BECAUSE I CAN'T SEE NO OTHER DOCTOR.

Telephone disconnected. Letter and booklet sent to client with relevant info underlined and name of specific worker to contact.

THE REASON I SAY THE CARE IS WORSE IS BECAUSE I WAS SEEING A CHIROPRACTOR FOR MY BACK PROBLEMS. I HAVE TWO SLIPPED DISCS THAT GIVE ME PROBLEMS. NOW I CAN'T GO TO MY CHIROPRACTOR BECAUSE I WAS FORCED TO CHOOSE ONE DOCTOR. I DECIDED TO STAY WITH MY MEDICAL DOCTOR IN CASE I HAD SOME PROBLEMS LIKE INFECTIONS THAT MY CHIROPRACTOR COULDN'T HELP ME WITH. NOW MY BACK IS GIVING ME PROBLEMS BECAUSE I HAD TO QUIT SEEING MY CHIROPRACTOR. I DON'T THINK THIS IS FAIR. I THINK PEOPLE SHOULD BE ABLE TO HAVE A CHIROPRACTOR AND A MEDICAL DOCTOR. I DO NOT RUN UP HIGH BILLS. I ONLY SEE MY MEDICAL DOCTOR ONCE EVERY COUPLE OF YEARS.

Sponsor Specialist worker contacted client and explained exemptions from authorization and also all the case management options available to the client.

MY DENTIST GAVE ME A PRESCRIPTION. THE PHARMACIST DIDN'T HAVE HIS NAME IN THE COMPUTER AND WANTED TO KNOW WHY THE PRESCRIPTION WASN'T FROM THE DOCTOR LISTED ON MY CARD. HE FILLED THE PRESCRIPTION BUT PUT ANOTHER DOCTOR'S NAME ON IT. ALSO WHEN I CALLED MY DOCTOR I COULD NOT GET AN ANSWER. I WOULD LIKE TO KNOW WHY WE HAD TO SIGN UP AT ALL.

Sponsor Speicalist worker spoke with client regarding prescription from dentist and 24-hour access of sponsor. She stated that there really wasn't much of a problem with pharmacy. Sponsor Specialist worker advised her that pharmacy is to honor prescriptions from any doctor, even non-sponsors. Client instructed to call Sponsor Specialist unit if any problems arise. Sponsor doctor has been contacted regarding 24-hour access resolution.

I APPLIED FOR HMO AND NEED IT, BUT HAVEN'T GOT IT. I THINK THE SPONSOR PLAN IS GOOD AND VERY HELPFUL. I'VE NEVER HAD IT BEFORE.

Client has no telephone. Booklet and letter with personal note mailed to the client.

I'VE GOT SEVERAL QUESTIONS AND SINCE I HAVE NO PHONE, WOULD LIKE TO KNOW IF THESE CAN BE REFERRED TO SOME ONE WHO WILL RESPOND IN WRITING:

1. IS IT TRUE THAT I WOULD LOSE MY MEDICAID BY NOT PICKING A SPONSOR? I WAS FORCED BY MY DSS WORKER TO PICK A DOCTOR FOR MYSELF AND FOR MY DAUGHTER WITHOUT BEING GIVEN TIME TO FIND A PEDIATRICIAN FOR HER IN THE AREA WHERE I LIVE.
2. CAN I CHANGE OR DELETE A SPONSOR IF I FIND A BETTER DOCTOR OR ONE CLOSER TO MY HOME?

3. I WAS BEING TREATED FOR HIGH BLOOD PRESSURE AND NEED A REFILL BUT IT WAS NOT PRESCRIBED BY MY SPONSOR (A DOCTOR WHOSE NAME I WROTE DOWN ONLY BECAUSE IT WAS THE ONLY NAME I COULD THINK OF AT THE TIME) WHAT DO I DO?
4. MY DAUGHTER WHO IS EIGHT YEARS OLD NEEDS A CHECK UP. THE SPONSOR I PICKED FOR HER IS LOCATED WHERE WE USED TO LIVE WHICH IS SOME DISTANCE FROM OUR PRESENT LOCATION. CAN I TAKE HER ELSEWHERE? THESE ARE NOT THE DOCTORS I PREFER, BUT THEY ARE THE NAMES I WROTE DOWN BECAUSE I WAS PRESSURED TO SIGN UP IMMEDIATELY. HOW DO I CHANGE?

I WOULD APPRECIATE IT IF I WERE GIVEN SOME TIME TO FIND A SUITABLE SPONSOR, ESPECIALLY FOR MY CHILD. I THINK PEOPLE WHO ARE ON ASSISTANCE DESERVE SOME RESPECT, EVEN THOUGH THEY ARE POOR. IF I WERE WORKING, I'D BE ABLE TO SHOP AROUND FOR AN APPROPRIATE PHYSICIAN, ONE I'D BE COMFORTABLE WITH. SINCE BEING ON ASSISTANCE I'VE NOTICED THE ATTITUDE THAT THE PEOPLE IN CONTROL HAVE AS OPPOSED TO HOW I WAS TREATED WHEN WORKING. I'VE HAD TO CONTACT DSS WORKERS BOTH AS A LANDLORD AND AS SOMEONE DEPENDING ON THAT SAME WORKER FOR ASSISTANCE. IT IS A SHAME THAT YOU PEOPLE DON'T REALIZE THAT WE ARE STILL HUMAN AND HAVE SOME SELF RESPECT. MOST OF US ARE ASHAMED TO HAVE TO DEPEND ON THE STATE TO LIVE, BUT REALIZE THAT IN ORDER TO FEED OUR CHILDREN, WE HAVE TO SWALLOW OUR PRIDE. BUT, WE DON'T NEED THREATS AT EVERY TURN, NOR DO WE HAVE TO BE MADE TO FEEL THAT WE ARE SECOND CLASS CITIZENS. I WOULD LOVE TO WORK FOR THE DEPARTMENT OF SOCIAL SERVICES, I THINK I'D BRING A LITTLE COMPASSION TO THE JOB. AS I SAID, I WAS FORCED TO CHOOSE SPONSORS THAT I DID NOT WANT UNDER THREAT OF LOSING MY MEDICAL INSURANCE.

Client mailed a letter explaining PPSP and answering her specific questions regarding changing sponsors, pharmacy policy regarding non-sponsors, referrals to other doctors and selection of a health care plan. Client was also mailed the three plan booklet and asked to call or write if she had further questions.

HOW CAN A PERSON CHANGE DOCTOR'S?

Sponsor Specialist worker spoke with client on the telephone. She stated she was aware of procedure for changing doctors but has not decided to change at this point. She stated that the reason she stated that her medical care has gotten worse since she enrolled in PPSP is that her doctor has changed hours so that he is now available only one day per week. There are no other specific problems. Gave her the 256-9344 number to call when she decided to change doctors or has any questions.

I WENT TO A CLINIC WHEN I GOT WATER IN MY EAR AND THEY REFUSED TO GIVE ME HELP BECAUSE I HAD A SPONSOR. WHERE SHOULD I HAVE GONE? IT WAS A PAINFUL 2 DAYS BEFORE IT CLEARED ITSELF UP.

Sponsor Specialist worker telephoned client and explained referral process and 24-hour access provision of PPSP. Also gave client Sponsor Specialist telephone number to call if she should have further questions or problems.

MY DOCTOR OFFICE WASN'T OPEN AND IT WAS AN EMERGENCY. WE RECEIVED AMBULANCE SERVICE TO THE NEAREST HOSPITAL, BUT I WAS ALSO CHARGED \$25.00. I WISH I COULD GO BACK TO THE OLD WAY WHERE YOU COULD GO TO SEE ANY DOCTOR THAT ACCEPTED MEDICAID, ALSO THAT WAY YOU COULD GO THE NEAREST DOCTOR IN EMERGENCIES.

Booklet and letter with personal note at the bottom mailed to client regarding billing \$25.00 charge for emergency room.

I WOULD REALLY RATHER HAVE THE MEDICAID WE HAD BEFORE THIS. I DON'T LIKE BEING RESTRICTED TO JUST ONE DOCTOR. I PREFER A FAMILY PHYSICIAN FOR ME AND THE KIDS WITH THE OPTION OF BEING ABLE TO SEE MY GYNECOLOGIST. NOW I'M FORCED TO SEE MY REGULAR DOCTOR FOR FEMALE PROBLEMS AND THAT MAKES ME VERY UNCOMFORTABLE.

Client has no telephone. Letter and booklet with information on referrals sent to client. Client asked to call if there are further questions or concerns.

I DON'T SEE ANYONE IN PARTICULAR. I JUST SEE ANYONE WHO IS IN BECAUSE THE ONE DOCTOR I LIKE DIED. WHEN I ASKED TO GO TO A SPECIALIST THEY SENT ME TO ONE I DID NOT LIKE AND I WILL NOT GO BACK. THE CLINIC HAS ITS OWN PHARMACY AND YOU CAN'T GET PRESCRIPTIONS ANYWHERE BUT THERE. THEY HAVE BEEN CHARGING A CO-PAY FOR A YEAR SINCE I SIGNED UP EXCEPT THIS LAST TIME.

Client states she was in a bad mood when she filled out the questionnaire. She stated that the prescriptions she paid a co-pay for were purchased before she enrolled in the sponsor plan. Client is a Medicare/Medicaid client and has a choice about PPSP participation. She states she will stay in the program for now.

THERE IS NOTHING WRONG WITH THIS PROGRAM BUT I DO NEED TO CHANGE MY DOCTOR.

Client did not answer the telephone when Sponsor Specialist worker made several attempts to call. Letter and booklet mailed to the client.

THE MEMBERS OF MY FAMILY HAVE THE SAME HEREDITARY MUSCLE DISEASE BUT WE DO NOT BELONG TO THE SAME DOCTORS OR RESEARCH ORGANIZATIONS. WE ALL SHOULD RECEIVE SPECIAL MEDICAL ATTENTION, BUT WE DON'T.

Client has no telephone. Letter asking client to contact Sponsor Specialist Unit and three plan booklet mailed.

I WENT TO THE EMERGENCY ROOM AND THEY SAID TO CALL MY SPONSOR BEFORE THEY COULD HELP ME OR I WOULD BE BILLED AFTER RECEIVING TREATMENT. MEDICAID IS WONDERFUL, BUT THE SPONSOR PLAN IS NOT. WHEN I GO TO THE EMERGENCY ROOM I DO NOT WANT THE APPROVAL OF MY SPONSOR BEFORE TREATMENT.

Client has no telephone. Letter and booklet mailed.

CUT IT OFF! I DON'T NEED THIS S__! I WANT IT STOPPED! I HAVE WORKED FOR THE LAST YEAR.

Client has no telephone. Has been continuously active in Medicaid since April 1983. Letter and booklet sent to the client.

I REALLY DON'T UNDERSTAND ABOUT THIS MEDICAID SPONSOR PLAN. ALL I DO KNOW IS WHEN I RECEIVED MY MEDICAID CARD ONE DAY MY DOCTORS NAME WAS ON IT. I REALLY DON'T LIKE IT. I WANTED TO GO ON A DIET BUT THEY SAID I NEEDED TO SEE MY SPONSOR DOCTOR BEFORE I COULD BE SEEN BY ANOTHER DOCTOR, JUST TO SEE IF IT WOULD BE OKAY.

Client has no telephone. Letter and booklet mailed.

YOU GET ALL YOUR PILLS FREE AS LONG AS YOU GET THEM AT THE DOCTOR'S OFFICE.

Client has no telephone. Letter and booklet mailed.

ARE YOU ALLOWED TO SEE ANY DOCTOR OF YOUR CHOICE, EVEN THOUGH YOU HAVE A FAMILY DOCTOR?

Clients main concern regarding referral regarded possible surgery. Doctors stated she did not know if she could make a referral to a specialist according to the client. Sponsor Specialist worker explained process to the client. Client was satisfied and was pleased to get a call from a PPSP worker.

I HAD A PROBLEM WHEN THE PHARMACY COULDN'T CONTACT MY SPONSOR. ALSO, I DON'T LIKE HAVING TO SEE THE DOCTOR AT A SMALL UNKNOWN HOSPITAL. I AM USED TO GOING TO A MAJOR HOSPITAL FOR MYSELF AND MY CHILDREN.

Contacted via telephone and discussed her preference of site to receive care. Stated that the doctor was not a sponsor so she had chosen one who was because her worker informed her that she could no longer have a straight Medicaid card. Objects to the small hospital her current doctor works out of. She prefers a particular large hospital but SSU worker explained that if she wanted to go to that hospital she would have to join the hospital based HMO, as would the other members of her family. Client stated that she wanted to discuss it with the HMO representative before mailing a decision. SSU worker gave her the name and number of a representative at that HMO that she could speak with. Regarding pharmacy, pharmacist insists on phoning the sponsor prior to filling prescriptions. This is time consuming but is the policy at this pharmacy.

THEY HAVE TO CALL MY DOCTOR ALL THE TIME FOR PRESCRIPTIONS. I WOULD JUST LIKE TO HAVE MY PLAIN CARD BACK.

Message left with client's mother to have the client call the Sponsor Specialist office. Client was also mailed a letter and a booklet regarding PPSP. At the time of this writing no response has yet been received.

I RECEIVED THE SAME MEDICATION TWICE, ONCE BECAUSE I BELIEVE THE PHARMACY DID NOT KNOW WHAT IT WAS. WILL THE MEDICATION FOR MY BABY WHO IS NOT BORN YET BE COVERED BY MEDICAID?

Client states druggist gave her two prescriptions for cough syrup instead of constipation as the doctor had prescribed. The client did not alert druggist to mistake but went to another pharmacy. Client is happy with her sponsor's services. Client also stated concern regarding prescriptions being filled before the name of her yet unborn baby is entered on the computer by her local case worker. She stated she had difficulty in the past. She was referred to her AP worker for instructions.

BEFORE I CHANGED DOCTORS IT SEEMED LIKE IT WAS THE DOCTOR WHO CAUSED THE PROBLEM BECAUSE THEY DON'T WANT TO SETTLE FOR THE AMOUNT THE STATE CAN PAY. THE LEVEL OF HEALTH CARE IS BROUGHT DOWN.

Client explained that doctors don't want to accept what Medicaid pays. Seems not to care or conduct thorough examinations on Medicaid clients. States her doctor sometimes charges for things that are not done. She has switched doctors and is now satisfied with the care she and her daughters have received. Client was appreciative of the call.

I WOULD LIKE TO CHANGE MY SPONSOR ON MY MEDICAID CARD.

Client has no telephone, incorrect number was written on form. Sponsor Specialist worker mailed client a letter and booklet.

MY DOCTOR GETS UPSET IF I ASK TOO MANY QUESTIONS. I WILL BE CHANGING DOCTORS BECAUSE OF THE WAY HE TAKES CARE OF MY DAUGHTERS. HE DOES NOT REALLY CARE OR TAKE TIME TO FIND OUT WHAT THE PROBLEM IS, HE JUST ASKS YOU AND THAT'S ABOUT IT.

Client is not unhappy with her sponsor. She was unaware of the referral system. This was explained to her. Her current sponsor is a specialist and she wants to find another doctor for herself and children. Client expressed appreciation for information and concern.

I WOULD LIKE TO SEE ANOTHER DOCTOR, THIS BECAUSE THERE ARE OTHER THINGS I NEED TO SEE ABOUT THAT MY DOCTOR DOES NOT TAKE CARE OF. I WOULD LIKE OFF THE SPONSOR PLAN.

Clients phone has been disconnected. Letter and booklet mailed to the client with portions underlined.

MY DOCTOR LEFT PRACTICE AND HIS OFFICE PARTNER BECAME MY SPONSOR. I NEEDED SOME TESTS AND ASKED IF I COULD GET THEM AT A HOSPITAL I HAD BEEN TO BEFORE. I GOT APPROVAL AND HAD THE TESTS, BUT ALSO GOT A BILL. I HAVEN'T GOTTEN THE RESULTS OF THE TESTS. BUT I'M TOLD I HAVE TO PAY \$458.00. THE HOSPITAL SAYS HE DOESN'T HAVE THEM. ALSO, WHEN I WENT TO HIS OFFICE FOR CARE (I CALLED FIRST TO SEE IF THEY COULD TAKE ME) I WAITED A LONG TIME. MY DAUGHTER DROPPED ME OFF AT 12:30 p.m. AND IT WAS 4:00 WHEN THEY WERE DONE TREATING ME.

Case was referred to Project Director for follow-up action.

WELL, I LIKED MY SPONSOR BECAUSE THE OFFICE WAS CLOSE BY AND THEY HAD TRANSPORTATION SERVICE. NOW I HAVE MOVED AND I NEED A NEW SPONSOR. I HAVE BEEN TAKING MY SON TO A HOSPITAL FOR CARE AND I LIKE IT. SO, HOW DO I GO ABOUT CHANGING MY SPONSOR?

Client not at telephone number listed on enrollment form. Letter and booklet mailed.

MY DOCTOR SPONSOR IS SENDING ME TO A SPECIALIST THAT I THINK IS NOT DOING ME ANY GOOD. HE HAS DONE AN OPERATION ON ME THAT HAS NOT HEALED UP YET. I AM HAVING A PROBLEM WITH IT. COULD YOU PLEASE SEND ME A LIST OF SURGERY DOCTORS THAT ARE ON THE SPONSOR PLAN. I HAVE HAD SURGERY FIVE TIMES THAT HAVEN'T HEALED UP RIGHT.

Client has no telephone, letter and booklet mailed to the client.

I HAVE NOT GONE FOR A SECOND OPINION YET. THE DOCTOR IS TRYING TO SEE IF HE CAN USE MEDICATION TO BRING MY PROBLEM UNDER CONTROL. IF HE CANNOT, A HYSTERECTOMY IS NEEDED. BEFORE THAT HAPPENS, I WISH TO FIND MY OWN SECOND OPINION DOCTOR. MY SON GOES TO AN ALLERGIST. HE HAS ASTHMA AND HIS SHOTS FOR BREATHING WHEN HE IS ILL ARE NOT COVERED BY MEDICAID. ALSO I WENT IN AND HAD SURGERY AND THEY TREATED ME LOUSY, AND I NEVER ASKED THEM FOR A THING. ALSO, MY TEETH ARE IN BAD SHAPE AND MEDICAID WON'T COVER THE ROOT CANALS DESPERATELY NEEDED TO GET MY TEETH FIXED. JUST BECAUSE I'M OVER 21 SHOULD I HAVE TO SUFFER? THAT'S IGNORANT I THINK. IF YOU'RE OVER 21 THEY SAY THEY CAN GIVE YOU FALSE TEETH. WHERE DOES THAT GET YOU EMOTIONALLY? MY TEETH HAVE ONLY DECAYED THIS BAD BECAUSE OF MEDICAID NEGLECT. NOW I AM ALWAYS IN PAIN AND EVEN ILL FROM THEM.

Client does not have a telephone. She will have to phone Sponsor Specialist office for help. This was explained to her in a letter that was mailed along with three plan booklet.

I WAS ENROLLED. I DIDN'T KNOW ABOUT IT UNTIL I GOT MY MEDICAID CARD AND A DOCTOR'S NAME WAS PUT ON THE CARD.

Clients first contact with the sponsor plan was the control group. Her phone number was changed to an unpublished number so contact could not be made. Letter and booklet mailed to the client.

I HAVE BAD TEETH AND AS A RESULT I HAVE A LOSS OF BONE FROM THE UPPER AND LOWER MANDIBLES. I APPLIED FOR UPPER AND LOWER DENTURES BUT THEY ONLY APPROVED UPPERS. PLUS, AFTER THEY PULLED THEM OUT, I HAVE TO WAIT TWO MONTHS BEFORE THEY CAN MAKE THEM. CAN YOU IMAGINE GOING THAT LONG WITHOUT TEETH? I PERSONALLY CAN'T BELIEVE THEY CARE MUCH OR CAN DO THIS TO PEOPLE WHOSE ONLY PROBLEM IS NOT BEING ABLE TO FIND A JOB.

Letter and booklet mailed to the client as she has no telephone.

I WOULD LIKE TO KNOW HOW I CAN CHANGE MY SON'S SPONSOR TO ANOTHER DOCTOR SO THAT HE MAY RECEIVE WIC OR FOCUS HOPE. BUT, I DO NOT WISH TO CHANGE MY SPONSOR.

Sponsor Specialist worker attempted to make contact with client three times. Message left for client, but no return call received at the time of this writing. Letter and booklet mailed to the client.

I JUST CHANGED THE MEDICAID SPONSOR FOR MY CHILDREN FOR THIS MONTH AND I WOULD LIKE TO CHANGE IT BACK TO THE REGULAR SPONSOR DOCTOR THAT WAS ON LAST MONTHS CARD. THIS CHANGE WAS DONE BY MISTAKE.

Client made contact with Sponsor Specialist staff and made the change back to her regular sponsor. This will appear on the clients September Medicaid card.

MY DOCTOR IS NOT A DOCTOR FOR YOUR HEALTH, SHE IS JUST A GYNECOLOGIST. I DON'T HAVE A REGULAR DOCTOR. I DIDN'T UNDERSTAND THE APPLICATION WHEN I FILLED IT OUT.

Client has changed sponsor and is happy with her present doctor. She did not understand the referral system though. Sponsor Specialist worker explained this to her in detail.

I WOULD LIKE TO KNOW HOW TO GO ABOUT SEEING A SKIN DOCTOR. CAN I JUST GO TO MY HOSPITAL, THERE IS A DERMATOLOGIST ON STAFF THERE.

Referral process explained and booklet mailed to client.

MY MEDICAID WAS CUT OFF FOR TWO MONTHS. I REAPPLIED BUT I DON'T HAVE A CARD YET. I HAD AN AUTO ACCIDENT AND NEED X-RAYS BUT CAN'T PAY FOR THEM NOW.

Everything has been resolved at this time. Client is pleased.

I AM IN AN HMO PLAN THAT I DON'T LIKE. EVERY TIME I GO THERE FOR AN APPOINTMENT I ALWAYS HAVE TO STAY ALL DAY. I HAD A 10:00 O'CLOCK MORNING APPOINTMENT AND DIDN'T GET OUT OF THERE UNTIL 4:00 O'CLOCK. I SIGNED A DISENROLLMENT SHEET BUT THEY DID NOT LET ME GO. I AM DISPLEASED.

Client has had telephone number changed to an unpublished number. Sponsor Specialist worker was unable to explain disenrollment procedure from an HMO. Letter and booklet mailed to the client.

I HAD TO CHANGE SPONSORS IN ORDER TO SEE A DOCTOR FOR A SECOND OPINION. THEY FINALLY GOT AN AUTHORIZATION NUMBER AFTER GOING TO THE OLD DOCTOR AND GETTING THE RECEPTIONIST TO GIVE IT. CHANGE IT BACK TO THE OLD WAY LIKE IN THE BEGINNING. GIVE ME MEDICAID WITHOUT SPONSORSHIP.

Letter and booklet sent to this client as she has no phone.

I HAD TO WAIT TO GET AN OKAY FOR TREATMENT WHEN MY DAUGHTER COULD NOT GET HER BREATH. THAT WAS LOST TIME WHEN IT COULD HAVE CRITICAL.

Client has no telephone, letter and booklet mailed to client with portion on emergency room underlined.

I NEVER HAD ANY OF THESE THINGS BECAUSE MY WORKER NEVER DID TELL ME ABOUT THEM. THE ONLY THING I COULD SOMETIME GET WAS A VOUCHER TO SEE MY FAMILY DOCTOR. I WOULD LIKE TO HAVE A MEDICAID CARD SO I CAN SEE MY DOCTOR OFTEN LIKE I AM SUPPOSED TO. I HAVE HIGH BLOOD PRESSURE AND I NEED TO TAKE MY MEDICINE EVERY DAY BUT I CAN'T ALWAYS. SOMETIME I DON'T GET EVERYTHING AT ALL. THIS IS NOT HELPING MY HEALTH AT ALL.

Client has been changed to General Assistance Medical. No longer has Medicaid.

I WAS FORCED TO CHANGE DOCTORS BECAUSE OF MY SPONSORS OFFICE HOURS. MY REGULAR DOCTOR WHO WAS ONE OF THESE SPONSORS WAS TAKEN AWAY AND I WAS TOLD I HAD TO GET ANOTHER ONE. I PICKED ONE WHO WAS CLOSE TO MY HOUSE. MY CARE HAS GOTTEN WORSE SINCE I CHANGED MY SPONSOR. I HAD A DOCTOR BUT I WAS TOLD I COULDN'T GO TO HER ANY MORE BECAUSE HER OFFICE HOURS WERE NOT EXTENSIVE ENOUGH. EVEN THOUGH SHE DIDN'T SATISFY THE REGULATED HOURS YOU EXPECT, SHE HAD GIVEN ME BOTH HER HOME NUMBER AND A NUMBER TO REACH HER AT THE HOSPITAL SO SHE WAS AVAILABLE TO ME AT ALL TIMES. I HAVE A LOT OF HEALTH PROBLEMS AND SHE WAS THE FIRST AND ONLY DOCTOR TO COMPLETELY INVESTIGATE MY PROBLEM AND THE PROPER MEDICATIONS I SHOULD USE. SHE HAD ME FEELING WELL ENOUGH THAT I ONLY HAD TO GO IN ONCE A MONTH. NOW I HAD TO FIND ANOTHER DOCTOR AND HE DOESN'T LISTEN. HE RUNS IN AND OUT OF THE ROOM SO FAST I HARDLY KNOW HE'S BEEN THERE AND I'M ALREADY FEELING WORSE. I ALSO FEEL FRUSTRATED AND LOST. IF SHE WAS MEETING MY MEDICAL NEEDS, WHY SHOULD I HAVE TO GIVE HER UP AS MY DOCTOR. MY DAUGHTER IS SO UPSET ABOUT LOSING HER AS OUR DOCTOR THAT SHE REFUSES TO GO TO THE DOCTOR.

Client states doctor is still in practice. She explained the situation. Sponsor Specialist worker explained referral process to see if her current sponsor will make a referral to the doctor she wants to see. Client stated she would do this.

IF POSSIBLE I WOULD LIKE TO KNOW HOW MEDICAID HANDLES THIS PROBLEM. I TOOK MY SON TO THE HOSPITAL TO GET AN X-RAY. I HAD A PRESCRIPTION FOR IT FROM MY DOCTOR. THE HOSPITAL SENT ME THROUGH THE EMERGENCY ROOM. I DIDN'T WANT TO GO. I JUST WANTED AN X-RAY. I GOT THE X-RAY BUT I'M ALSO BEING BILLED BY EMERGENCY. THEY HAVE TURNED MY NAME OVER TO A COLLECTION AGENCY. I HAVE MEDICAID.

Three attempts were made to contact this client but no answer at telephone number listed on the form. Letter and booklet sent to the client.

I DON'T THINK THAT THE DOCTOR IS VERY COMPETENT. I WOULD NEVER GO TO THIS DOCTOR AGAIN FOR PRENATAL CARE BECAUSE HE IS NOT INTERESTED IN HIS PATIENTS.

Client has changed telephone number to an unlisted number. Letter and booklet mailed to the client.

I NEED TO KNOW ANYTHING ABOUT OR HAVE ANY INFORMATION ABOUT DENTAL COVERAGE AS I HAVE A VERY BAD TOOTH PROBLEM.

Clients telephone has been disconnected. Letter and booklet mailed to the client.

I WAS TRICKED OR LIED TO ABOUT AN HMO. I WAS TOLD BY A SALES PERSON THAT WAS WALKING IN THE NEIGHBORHOOD THAT MEDICAID WAS GOING TO STOP EMERGENCY CARE, PRESCRIPTIONS AND OTHER THINGS AND LEAVE US A.D.C. PEOPLE OUT IN THE COLD. I PANICKED BECAUSE I BELIEVED IT. I CARELESSLY SIGNED SOME PAPERS. THEN, I CALLED MY DOCTOR AND HE TOLD ME TO CANCEL AND CONTACT MY WORKER AND LET HIM KNOW WHAT HAPPENED. I CALLED TO CANCEL AND THE LADY SAID I HAD TO WRITE THEM A LETTER OR COME DOWN TO THE OFFICE IN DETROIT. I LIVE IN INKSTER AND I TOLD HER I DIDN'T HAVE TRANSPORTATION. SHE SAID THEN WRITE A LETTER. I WANT TO BE OFF. TAKE ME OFF THE HMO PLAN.

Client claims that a salesperson told her that there would be no more Medicaid and that all prescriptions and emergencies would be billed to the client. Client also states that the salesperson stated the place she was representing was not an HMO. Sponsor Specialist worker explained disenrollment procedure and asked client to call back if there were further difficulties or questions. Case forwarded to HMO Unit in Lansing.

I DON'T REALLY KNOW THAT MUCH ABOUT THIS MEDICAID SPONSOR PLAN. WHAT IS IT? IF I WROTE DOWN WRONG ANSWERS TO THESE QUESTIONS IT ONLY MEANS THAT I DON'T UNDERSTAND THE PROGRAM. PLEASE TELL ME MORE ABOUT THIS. I PHONED 256-9344 FOR QUESTIONS ABOUT THE MEDICAID SPONSOR PLAN AND ALL I GOT WAS A BUSY SIGNAL.

Client called Medicaid Monitoring staff and was told about the Plan. She asked for printed information so booklet will be mailed. She was told to keep trying the 256-9344 number for answers to specific questions.

CLIENT COMMENTS FROM MONITORING QUESTIONNAIRE

Client Lacks Understanding/Information Regarding Case Management

I read the book but I didn't understand it. Now I know where to call so they will explain it to me.

I can't say, I don't know much about it.

I signed my granddaughter up with my doctor because I thought that there could be just one sponsor per family. She needs to see a pediatrician so I have been taking her to one and paying for it. I'm glad you told me to call and that I could list my doctor for me and the pediatrician for my granddaughter. I called and a nice man helped me get the pediatrician on the card for June.

My sponsor is an OB/GYN and I want to see a general practitioner. How do I do this?

Since you give three choices of types of service - you should explain them more fully. Where is the list of doctors that will take Medicaid? How far from my house are the HMO's? I would like more information for my area. After I signed up with a sponsor I found out he is no longer accepting Medicaid recipients.

The information I received should have been more explanatory. Perhaps with more information I would have picked a different plan.

I didn't receive any information and therefore I know nothing about this.

I think more people should know how to change their sponsor if necessary. This could be quite important and this form is the first knowledge I've had that a sponsor could be changed.

At first I thought the Medicaid Sponsor Plan with only my doctor's name on it meant I didn't have other Medicaid covered services like dental care, eye care, and specialists. But I have had dental care and also found out I could see a specialist if I need too.

I didn't know that I could get help in changing from my present sponsor to another one who would want me as a patient. I'm going to call.

Could you please send me information on HMO's.

Who is my sponsor? What is a sponsor? Is it my regular doctor? I don't know what you're talking about. I didn't know I joined a Sponsor Plan. All I did was ask for ADC and I got a sponsor with it.

I didn't have this telephone number before I got this form but now I do.

If a serious problem occurred and my doctor couldn't be contacted, would the hospital emergency staff treat me?

Am I always limited to go to the Medicaid sponsor? What if this doctor is unavailable or moves away?

Nobody told me there was an office to call if I had questions.

Enrollment Related Concerns

I signed up for a sponsor before Medicaid could assign me to one I did not know.

I was told my doctor would not be able to treat me if I did not sign up because he wouldn't get paid.

I do hope that things will work out on the sponsor plan because they have too many people coming to your house trying to get you to join other groups.

I was told if I didn't sign up for this plan I would have to pay more for my medicine so I signed up.

I only signed up because my worker said I had to put a doctor on my card.

My worker said I had to pick a doctor.

The doctor I signed up with said he could not accept any new Medicaid patients and that we would have to change. Why did they let me sign up?

I got a letter in the mail stating that I had to have a sponsor doctor.

At this time it is too early to say anything about this because I just signed up for the plan. I was talked into signing up with an HMO and I didn't like it because I found out I would have to change from the doctor I've been seeing for years. I switched to the sponsor plan quickly so I can continue to see my doctor.

My doctor retired and the doctor that took over said that all her patients had to sign up with her as a sponsor.

Uncertain About Participation PPSP

I don't think I signed to join a sponsor plan.

I don't have any kind of sponsor doctor and am not in any plan, thank you.

Enrollment Errors

I don't have a doctor for me, just one for my baby. They put my name down with that doctor which caused some problems for a while.

My children were seeing a pediatrician and I signed them up with him. When my Medicaid card came they had signed me up with him too.

Referral to a Specialist/Second Opinion

I needed to see an OB/GYN but I was afraid to ask my doctor because he would send me to the one of his choice and not the one I go to.

The specialist I was referred to did not take Medicaid, so I never went even though my sponsor gave me his name.

I was referred to a specialist by my sponsor. I haven't heard anything back from him though, and I saw him more than three months ago.

There is one problem that I hope will never arise and this is getting approval from a sponsor doctor when you need to see a specialist. Other than that the program is okay.

I will ask my doctor about a second opinion and then call you back if I need you.

The only complaint I have is why do you need to get a referral from your sponsor if they are in the same hospital as the specialist. My daughter had to see the skin doctor on one floor of the hospital, but before he would see her I had to go to another floor to get the sponsor to give a referral. It already says that my doctor is a doctor on staff there and not some drug doctor on the corner.

Before I chose a sponsor I asked the doctor I was going to if he could refer my daughter and me to a female specialist that was recommended to me. The doctor said he did not know her. He recommended a doctor to me but I did not like that doctor at all. I then went to see the female specialist and now she is my sponsor doctor.

I have to see a specialist every six months because I have rheumatoid arthritis. In between these visits my regular doctor handles my care.

I don't understand in the case of getting glasses why if I want something extra like tinting or nice frames with my bifocals I could not pay the excess and have Medicaid pay what's necessary. What I understood is they won't pay at all for the lens if I did this or for the frames if I wanted more expensive frames.

Pharmacy

The pharmacy once refused to fill my prescription because my card had a different doctors name on it. I was told I would have to pay \$40.00 for the prescription.

I once went to the pharmacy and I forgot my card at home and they said they could not check it for me.

The doctor I go uses only one pharmacy and they are very expensive. I have to pay \$20.00 for my medication because Medicaid will not cover it.

I had a problem when the doctor said I needed to get a certain kind of medicine for my son and I was told that Medicaid would not pay for it.

The girl at the store said that the number on my Medicaid card meant I had another kind of insurance. Even though I had a sponsor doctor she made me pay the 50¢ co-pay. I called the Medicaid Sponsor person and got help with this problem with the drug store. I got all the information I needed and the lady was very nice. Thank you.

Change of Sponsor/Case Management

I changed my sponsor doctor because my doctor moved from the Downriver area.

I became pregnant so I went to an OB/GYN instead of my family doctor.

I changed my doctor to one who is closer to my home.

I picked a doctor who was closer to home.

I would like to be re-enrolled with the Clinic Plan.

I am going to change doctors this week, I'll let you know what happens if you want me to.

I want to change doctors when I find another one that I want to go to.

I changed doctors because my doctor's office was too far away. I am still pleased with this program though, except for the x-rays. I am very afraid for my children. They may become effected with radiation or catch a contagious disease or become ill for a long period of time.

My son is not with the same doctor but I am. I changed his doctor because his old doctor would no longer accept Medicaid. The doctor who did not accept Medicaid helped us find a specialist though. I do really appreciate the Medicaid Sponsor Plan for my son and me. It has been much help.

We changed sponsors to a doctor who is closer to home and has prompter appointments. When we needed to get a second opinion we took our daughter to a doctor we went to before we got on Medicaid and paid for the visit.

I changed sponsor because I was not satisfied with the doctor or his office hours.

Travel Difficulties

The only thing I don't like is I would occasionally like to go to my old doctor when I don't have transportation to our sponsor. The sponsor is a long way away but I don't want to change because he is good. Sometimes you have to have more than over the phone care, and I can't get all the way to the doctor. In this case I would like to go to another doctor and not to an emergency room because I know it costs more.

I have moved and now my doctor is far away from my house. It's hard to get there.

The doctor I am appointed to see is on the other side of town and I have no other specific doctor I want to see. For now I am really without a doctor since I don't have one on my side of town.

The reason I don't like the Medicaid Sponsor Plan is that sometimes I don't have a ride to the health center so my daughter misses some of her appointments. I'd rather just have my plain Medicaid card so that I could take her to any doctor near the house when I can't get transportation.

Comments About Sponsor Doctors

I like the doctor I selected.

I am satisfied with my doctor.

I like the service and advice I get from the doctor I am under. So far he has taken care of all my needs and is even open on Saturday.

I am very happy with my doctor. He has been my doctor for many years.

The doctor I went to for years left private practice and recommended another doctor. I was sorry to lose my sponsor because my relationship with him was very good.

I have had this doctor for a very long time.

I found the doctor and the nurses were very timely, efficient and cooperative. They were most understanding.

I don't really see any difference since I got the doctor I wanted for my son's sponsor. It's fine just as long as he is in it.

I sometimes have a hard time reaching my doctor because he has more than one office and I want to talk to him only.

Services not needed yet

I haven't been so I can't tell.

I just call for my prescription. I haven't seen a doctor for over a year. I can't tell you if it's better or not.

So far there hasn't been a need for a second doctor's opinion for treatment or an operation, nor for a referral to a specialist. However, I will not hesitate to ask for any of these for myself or for my children. If I have any questions I will certainly call the number stated on this form to get answers.

I have not used my doctor as a sponsor yet because nobody in my family has been ill.

I have not had to use my plan yet so therefore I am yet unqualified to judge it.

I can't find my Medicaid card so I can't tell you if I'm in this sponsor thing or not. I haven't been to the doctor lately.

It is very hard for me to describe how the sponsor plan works in regard to myself and my children because our health is very good and we rarely make visits to the doctor.

I have no comments, I just received information on the plan. I haven't been.

I haven't needed care since joining the sponsor plan.

Lack of Satisfaction with Care

I had a doctor I went to but I didn't like the care he gave me so I changed.

I didn't get much service for my daughter at one hospital so I had to take her to another one.

I'm very pleased with my doctor. But I would like to have my oldest son's doctor changed. I am not pleased with the care he gets at that office and I will be calling the office to have it changed.

Billing

I had to go to another clinic because they had my x-rays. I went in on a Sunday and I am being billed. I have been there before. Medicaid refused to pay.

My doctor referred me to a specialist and told him that I had Medicaid. He said he would see me because my doctor said it was okay, but now, I am being billed for the care.

Emergency Room

I feel they should be a little more lenient on what is considered to be an emergency. I took my son to the hospital because he was so badly impacted he was bleeding. Medicaid sent me a bill stating this was not an emergency and that I must pay the bill.

I went to an emergency room and got charged \$25.00.

24 Hour Access Concerns

The doctor has changed my pain medication to one that really upsets my stomach. When I went to the emergency room the answering service could not locate my doctor. My doctor said he didn't know about this incident but would check on it.

I called my doctor in the middle of the night and he told me to wait until the office opened.

Positive PPSP General Comments

I am satisfied with the plan.

So far everything is okay but I haven't been in any of the situations you are asking about so I haven't been able to see what the different results would be.

I think it's a very good program. Too many doctors get you confused and some drugs don't mix and make you very ill.

I like it because it helps me.

Yes its very good care. I have been in the sponsor plan now for a long time and I don't have any problems so far.

So far, the plan has been great. I have an excellent doctor and when I had to take my son to emergency he got a lot of good care and the wait was not that long.

Keep up the good work.

We are satisfied with the Sponsor Plan.

The Medicaid Sponsor Plan is working out fine with me and my daughter. I had no problems before this plan either. I know that it must be great for others too. Also your dental plan is beautiful. At first I was having problems getting money for a hygienist. Thank you very much for Medicaid.

When I signed off of an HMO I was told to sign up for the sponsor plan or the state would automatically put me back in the HMO. This didn't bother me at the time because I had planned on doing it anyway. At the HMO I was constantly being billed for everything and never knew where to go in an emergency. Their favorite line was that it was not pre-authorized. Compared to that the sponsor program is great.

I like the option we have to see another doctor if needed and that we can still seek medical attention at an emergency room at a local hospital if our situation is of an emergency nature.

I am completely satisfied with the Medicaid Sponsor program. I receive all the care and help I need with courtesy.

It works for us!

I haven't had to see a specialist or a second doctor but I know if I did my doctor would do what was right for me. There really isn't anything I can say until something happens to me. So far I have been treated very well on the Medicaid Sponsor Plan.

It's fine.

I'm glad to know I can get a second opinion because I need one for a medical problem I am having.

I am satisfied.

I am very satisfied with the Sponsor Plan. I have had no problems. I am so very glad I enrolled.

As of now I have received the same quality of service with my physician as before. I have no complaints with this program and thank you for your concern.

My doctor moved out of town so I had to find another doctor, but I am satisfied.

I would like to say that I believe what this organization is doing is marvelous. I know in my case the pain would have been impossible to endure because without this help I would not be able to afford the medication. God Bless all of you.

I haven't had any problems yet, but I haven't used it much.

I'm very satisfied.

I'm glad that it was made available for me.

We have had nothing but good experiences since joining the Plan. My husband had an allergic reaction to a chemical and there was not time to call anyone. He couldn't breathe. We went to the closest hospital (our doctor is not on staff there) and had absolutely no problems. Then our son had an emergency when he fell down the stairs. The doctors answering service could not get him right then so we took him to the emergency room. This was the night before Easter. Monday morning I called the doctor and explained the situation. He said it was an emergency and it was no problem and it would be covered.

It took me three months to changed from one sponsor who was very bad to the one I have now who is excellent. I am a diabetic and my old sponsor doctor had not checked my sugar level in over a year, that's not good medical practice. Now I get my sugar checked as often as needed. I like the Plan very much now.

I am a guardian for an adult in a foster care home. I called because I had a problem understanding this plan and spoke to a woman who answered all my questions. I would like to say thank you to who ever she was. I would also like to say that the Specialty clinic I take my ward to is the most complete clinic I have ever been in, and her sponsor is most helpful.

My main concern at the start of this program was that I would lose my family doctor. It was explained to me though, by my DSS worker that I would be able to keep my regular doctor. I have an excellent worker.

I hope this plan keeps on working and helps people like me.

I haven't been on this plan very long but the type of care we receive from our doctor hasn't changed and I'm happy with it so far.

As of now I am satisfied and my husband is too. We have no children. If I need help I will call.

The Medicaid Sponsor Plan has been good for my children and me. It's very good when you need it.

I have no trouble with this program.

I think it's great. I have a very good doctor who listens to me and treats me like a person. He is very understanding, and that is why I chose him as my doctor.

I think it has been improved since 2 years ago. It's much easier to understand with all the information offered at the time of application. It's better with a sponsor plan. You know your doctor will be contacted in a case of emergency.

I think that the sponsor plan is a good idea. That way it gives a chance to people to get to know one doctor instead of a different doctor all the time. It really cuts down on a lot of problems.

I am very pleased.

It's a good program and it's good because if my card is stolen someone else can't use it because my doctor knows me.

So far this is working out fine for me and my children.

I guess this is okay. I have no complaints about it so far.

So far with this I get very good services.

Pretty good program, keep up the good work.

I think this is such a great plan. Please keep up the good work.

Since I have a set income I think it is really nice and I appreciate the Medicaid Sponsor Plan very very much.

I am more than pleased with the Sponsor. I have no complaints at all. I like the fact that I could stay with my family doctor who I have been seeing for 14 years. This is better than a clinic which to me seems very impersonal. My daughter and I like the one to one relationship we share with our family doctor, instead of seeing a different doctor at each visit.

Negative PPSP General Comments

My children's pediatrician is on staff at a hospital that I don't like, and now we can't go to any other doctor.

Why do you have to have a sponsor in the first place? Why can't you see who you want to see?

I prefer the prior program. It enabled me to go to any specialist or any doctor when I felt the need without having to get an okay from my family doctor.

When joining the Sponsor Plan you should be advised that you'll only be allowed to see your sponsor in case of an emergency. Otherwise the sponsor doesn't want to be bothered and will tell you what to do right over the telephone. (Telephone interview, client given Sponsor Specialist telephone number and asked to call back if there were any difficulties).

I think it's a good plan for the ones who mistreat the help they get. But it makes it difficult when you need a different kind of treatment. It's a real run around. In my case I just moved to this area and didn't know any doctor to go to.

I don't really see where it is necessary to do this. Most people try to remain with a doctor they know and trust.

I don't like the service.

I wish we could go back to the old way. You could see any doctor that accepted Medicaid also then you could go to your nearest doctor in emergencies.

This program is a restriction. I feel like a little kid. I have teenagers, I'm a grown woman. This program is a headache. I think this is the worst. You can't go where, when or with who you want. If you're going to supply medical assistance you should be like other medical plans and see who you want to when you want.

I switched to an HMO because I had problems getting touch with my doctor when he was at the office. He was only in on Thursdays and my baby got sick on a Friday. I changed when he moved his office to the east-side because I have no transportation. It was just too much of a hassle.

I did not go the specialist my doctor wanted me to see because he was too far away to be convenient. This made it extremely difficult. When I found a specialist he would not see me because of the sponsor plan. I had to have them call my doctor to make arrangements through him. I understand that some people would abuse the program, but for those who respect it makes it difficult to have a free choice.

There is only one problem with the sponsor plan and that is that I have been refused treatment at the dermatologist because they could not contact my sponsor doctor. I have seen him before and think that if you have to see a specialist regularly for a period of time you should have automatic authorization until your treatment is complete. The doctors should communicate this information to one another.

I don't think it's really fair. You are forced to go to just one doctor or to an emergency room where you have to wait for hours and hours. You could go to a family clinic and not worry about this.

I don't care for it because I have to see other doctors for other problems and I can't afford to pay for another doctors care.

My husband and I would like to be taken off of the Medicaid Sponsor Plan. Our doctor who we have seen for 5 years left and so we started seeing one of the doctors on the Sponsor Plan. This doctor is no good. We would like to see a different doctor, one closer to us.

My child is a heart patient and this stops the care he gets, because I can't easily take him to the doctors he needs to see.

I think being restricted to a doctor that cannot see you when you need care is terrible. At least when I did not have a sponsor when my child or I needed care we had options and could go anywhere in the county. I think being restricted is terrible, especially when you can't get a doctor when you need one!

I am very dissatisfied with the doctor and the plan. I would like to change doctors and perhaps to choose a clinic plan where there are several doctors available. The plan is very limiting and restrictive. It is very hard to find a good dedicated caring doctor. It's twice as hard when you have Medicaid for health insurance. We are treated like second class citizens. I should know, I am a graduate practical nurse.

I would like to know why you can't see more than one doctor. If you have been seeing a doctor for years you need to get permission from another doctor to see him. My female doctor has been treating me since I had my daughter and she's twenty now. Now I have to see my family doctor first so he can say that I can go see my GYN. This is stupid.

For one thing if our sponsor doctor is not in at the time of a small emergency we are stuck, because there is no other doctor that we are covered by. It has to be a big emergency for Medicaid to pay for hospital care.

The treatment is not good from the doctor I have or from the hospital he works out of. My worker did not know about a sponsor office phone number or that I could change doctors. I was told by my worker that I'd have to go through Lansing if I wanted to change doctors.

I don't like the Medicaid Sponsor Plan because now when the children need medical attention I can only take them to my doctor who is quite a distance from our home. Also, when I call on weekends I have to call my doctor's answering service and wait until he contacts the office before getting advice. My son was swollen above his eye and the second time all the way down from his elbow to his hand. I couldn't take him to the emergency room because I had to contact my doctor first. My doctor did contact me with information on a prescription to get for my son. This new way is not convenient. The old way was much better and much more convenient especially for children.

Most women have more than one doctor, they have a medical doctor and a gynecological doctor for themself. Therefore, I feel I should retain the right to see who ever I chose. Not just one doctor. I also feel I should be able to be treated at any emergency room in any hospital, not just the one where my sponsor is.

I want to change doctors. I don't like my doctor and I hate the program. Everytime I look at my Medicaid card I feel degraded. It is so wrong to be treated in this way/ I am not an abuser and I resent being treated as if I am one.

I don't understand the need for this program.

You have to call too much to get an okay to be seen by another doctor now.

These days you have to see more than just a family doctor. You should be able to write down lots of doctors on your card.

I feel confined to this doctor who does not cover every need for me. I need to see an E.N.T. and also an eye doctor. My eyes have gone bad because of my blood pressure. my kidneys are also going bad and I can hardly hold my urine.

I like it better when I could see any doctor I wanted to see. My daughter's doctor is at one location and mine is at another's but now we go to the same doctor.

The doctor I picked was the last one that treated me and I felt he was a good doctor. But, it appears that he is not too happy with me choosing him and he keeps referring me back to the doctor I had before.

I think this plan is stupid and very inconvenient. There are too many hassles. This whole system is screwed up.

I was displeased with my sponsor so I changed so my child and I could get better care.

I think you should be able to go anywhere for care if you have a Medicaid card. Because someone tells you you have to pick a doctor or HMO or clinic plan you have to make a choice. I don't like it and I don't think it's right, but I'm trying to understand and you are only trying to keep medical costs low.

I had to change doctors because Medicaid kept losing my case and cutting me off. Therefore, I couldn't go to the doctor. I had to change to a doctor who would take my case as a pending case. I am pregnant and need medical attention and it was very upsetting.

The wrong doctor was on my Medicaid card. I have been seeing another doctor, a gynecologist regularly throughout my pregnancy.

There is a lot of time wasted since you have to get an okay to go for treatment at the emergency room.

I had to wait almost an hour before I could see anyone at the emergency room because I had to have my doctors okay. I didn't think that was right. What if it was a life or death emergency and they would not treat until they get the okay of the doctor.

A person should be able to get emergency service any time they go to the emergency room. It seems as though it's not possible like it used to be when there was no Sponsor Plan.

Why should you have a sponsor? I don't have any problem with my doctor, but when I need a specialist it's a lot of trouble to go back to the sponsor for a referral. Sometimes it's very inconvenient.

I called and called the number 256-9344 and always got a busy signal. I thought the telephone was broken so I called Michigan Bell and they told me the phone was off the hook. Why would they keep the phone off the hook when people have problems and need to talk to them.

I would still keep my doctor whether I was in the sponsor plan or not, but I think people should have the choice of going to any doctor you want. I can't see why you have to have just one certain doctor. I was told by my worker that if I didn't pick a doctor they would choose one for me.

I don't like it. I would like to go to any doctor I prefer because one day the sponsor doctor could be closed. I just don't like it at all.

I feel that at the hospital they shouldn't make you wait until they contact the Dr., to tend to the sick person. Even during a serious situation they make you wait.

Medicaid General Comments

I had my Medicaid cut off for two months but I re-applied and soon I'll have a Medicaid card again. I need to get x-rays but I don't have money to pay. Until I get the Medicaid back I can't get them.

Medicaid should pay for all shots that kids need. If the system is going to help it should do so fully.

The only problem I've had was that I was given a prescription that was not covered by Medicaid and I had to contact my doctor again to get something that was covered.

Medicaid was very good to us while we needed it, but this month my husband got a job and we are insured by another carrier.

My kids and I don't get Medicaid pay more. I work and support us now.

Medicaid won't pay for the kinds of medicine that I need.

I have been going to my doctor for a long time and if it's something he doesn't know about he will send me to a specialty doctor. Medicaid is alright. I wouldn't trade it for nothing. It's there when you need it and the doctor is nice and everything is there for you.

I am glad I receive Medicaid. Medicaid is great. If I didn't have it I would have had problems. Since I have had Medicaid one of my children had to have glasses and the other was recently involved in an accident. There is one problem with Medicaid and that is that I can't find a good doctor who will take it. I have hearing problem and I should see a specialist when I need to get my hearing checked, but I don't know of any who will take Medicaid. I do have my hearing checked with a regular doctor though. Other than that Medicaid is a good send.

I have been unable to get some of my prescriptions filled because of lack of money for medicines that are not covered by Medicaid, not because of the sponsor plan.

People are very discriminating about accepting Medicaid. You have to hunt to find someone to care for you.

I only had Medicaid for two months this time and I also had Blue Cross so I just used the Blue Cross. I didn't even apply for Medicaid. Six years ago I was on Medicaid for four years and I was treated badly because I was on Medicaid. The doctors I went to see didn't give my daughter the care she deserved. One doctor even told me "Since we were on Medicaid I shouldn't expect a lot of attention or very good care because they (doctors) lose money for each Medicaid patient they see". I think that stinks!

My vitamins are not covered and I need them but usually can't afford them. I am anemic but can only get my vitamins when I have extra money from my ADC check. When I do get it I only buy 1/4 because they are so expensive.

I appreciate Medicaid very much. I am grateful for the care I have through Medicaid.

I wish the Medicaid Sponsor Plan covered dental emergencies for people over 21 years of age.

Thank you for helping me right now until I can hopefully get back on my feet. I certainly do appreciate my Medicaid.

I would like to stay on Medicaid.

The medicine I need is not usually covered by Medicaid and it is hard to find.

I have no problems with Medicaid at all. I wouldn't know what to do without it.

I feel Medicaid is very caring insurance. I wouldn't want any other kind. Thank you so for your concern.

I assume that the Medicaid plan is alright for me and my children.

I am unhappy with Medicaid's lack of prescription coverage.

When my doctor prescribes something it's usually not covered by Medicaid and it's also usually something I cannot afford. I do not use Medicaid very often, because luckily neither I nor my son have had to, but I do appreciate that it is there should I need it.

For me and my family our Medicaid treatments have been very good. My child needed to see a specialist and we were sent to a hospital with a very good staff. I have been seeing my doctor since I was twelve years old and I wouldn't change him for another doctor.

It is good to know that there can be and is help when you need it without having to be concerned with a bill when you or your children are ill and can't afford to take them to the doctor's or get medicine. Medicaid is great.

I am quite pleased with the care we have been receiving through Medicaid. I was pleased to learn how fast and efficiently my baby who is not even born yet will be added to the Medicaid plan.

I went to an emergency room but it did not remedy my situation. What was wrong with me did not show up in my blood tests so they assumed nothing was wrong with me. Everytime I moved I had terrible pain and this continued something awful. It's good to have Medicaid though.

I don't know why I wasn't told that my Medicaid would be cancelled if I made too much money, and then I would have to sign up for it all over again. Why couldn't they just not give it to me for the one month that I made too much and then reinstate me without all of the hassle they put you through.

Medicaid only pays for dental emergencies, like to have tooth pulled. My teeth have to have something done to them, but I can't afford it. I have gum disease and the dentist I saw in California told me I had to have all my front teeth pulled and a plate put in. I can't afford this and Medicaid won't pay for it. It makes my teeth real bad and it hurts and hurts.

I have another insurance listed on my card but my worker won't take it off even though I don't have it anymore. It causes problems because they think I have some more insurance and they give me a hard time.

I would like to know the rules for dental care.

I don't have Medicaid for my whole family, just for me, they wouldn't give my family any.

I feel that Medicaid should use a computer to find duplication of services since there is a concern with cost control. For example someone who uses both Medicaid and Blue Cross/Blue Shield for services at different doctors.

My doctor called a doctor at a hospital about getting a built-up shoe for me. This was 5 months ago and I am still waiting for them to call me back about making an appointment. One of my legs is shorter than the other and this causes me lots of pain. I need the shoe, but Medicaid takes so long.

Medicaid is one of the best things that has ever happened to the indigent. I pray that it will always continue. Because of Medicaid I don't have to worry each day about what would happen to us if we need to see a doctor.

I need all my teeth pulled and to have false teeth put in, but I know this will take a long time to get done.

I think you have been great to us with Medicaid.

I hope that this will help us to be provided for with the best of everything so that we too can live long and happy lives.

My doctor would not take Medicaid so I had to find one that would.

The drugs that my doctor prescribed were not covered by Medicaid.

COMPLAINTS AND INQUIRIES FROM ENCOUNTER RECORDS

THE FOLLOWING IS A REVIEW OF THE RECORDS OF TELEPHONE CONTACTS WITH THE SPONSOR SPECIALIST UNIT STAFF. THE FIRST PART LISTS COMPLAINTS, MOST OF WHICH RESULTED IN A CHANGE OF SPONSOR OR PROVIDER. THE SECOND PART LISTS RECIPIENT AND PROVIDER INQUIRIES.

General Access Problems to Primary Physician

Client upset as the doctor listed on her Medicaid card is no longer a sponsor and has not been since January. Lansing was notified of this in January but name and location of doctor's office appeared on the sponsor list as late as May.

Doctor no longer in practice and could not be reached. Doctor has three locations and lists the same phone number for each. Retroactive disenrollment done for clients. Lansing notified.

Doctor stopped accepting Medicaid on May 1, 1986 but the name appeared on the clients June Medicaid card. Client has not yet found another doctor. Telephone call to doctor's office confirmed this information. Client disenrolled and corrected Medicaid card requested. Information relayed to Lansing.

Client went to doctor who is listed on sponsor list as a doctor who will take new Medicaid patients. Doctors staff states doctor's policy as of September 1985 is not to accept any new Medicaid patients.

Client has been enrolled with a sponsor for several months but had no need to see him until now. She was informed that this doctor was no longer taking new patients and would not see her. Client was disenrolled.

Client's doctor is no longer practicing at a given site. Determination needs to be made regarding this client and others enrolled with this sponsor.

Client in recipient monitoring. Doctor number given to client was a disconnected number. Client was referred to the recipient monitoring worker in her district. Sponsor Specialist supervisor notified regarding disconnected number.

Doctor no longer taking Medicaid however, name still appears on clients Medicaid card. Client filled out form for change with local office DSS worker.

Client's daughter (17 months old) was ill and client would not get transportation to the clinic. She called her pediatrician and he phoned a prescription in to a pharmacy near her home. Pharmacist stated he had no agreement with the clinic for payment and that the client would have to pay out of pocket or not get the script. Client told to bring receipt for prescription into the clinic and she would be reimbursed. Solution pending until payment is made to client.

Dr. no longer on staff at a given hospital. Clients disenrolled.

Clients doctor retired. She was admitted through the Emergency Room of a hospital for asthma. Another doctor at site gave authorization for treatment. This doctor is due to retire in several months. At that point he would like his patients transferred to another doctor who will practice at this site.

Doctor left practice. Lansing notified, clients disenrolled.

Enrolled with a doctor who had privileges at a certain hospital, when she attempted to get care at the hospital, she was denied service because the sponsor she enrolled with was no longer practicing there. Sponsor Specialist workers called the hospital and verified that the doctor had not been there since July 1985. Client was disenrolled. Supervisor of Sponsor Specialist Unit called Lansing and discussed matter with worker there who stated this doctors patients will be transferred to his replacements sponsor caseload. In the meantime, patients are being seen by other clinic doctors or authorizations are being given.

Doctor retired, client still enrolled with him. Client will be notified by mail to choose a new sponsor.

Client enrolled with doctor who discontinued practice. She was unable to get service.. Retro disenrollment done.

Client has been enrolled with a doctor at a hospital since February. When the client tried to get an appointment in May, she was refused based on this hospital's recent limiting of sponsorship to existing patients. The client and her son had not been to the doctor since enrolling. Client was disenrolled back to February date and corrected card was requested.

Doctor died, another doctor bought his practice and his records, this doctor is not a sponsor at this location. Client disenrolled and referred case to Lansing.

Sponsor only has hours on Saturday. This case was referred to Lansing regarding client access as well as sponsor's provision of 50 percent of the clients needed care.

Clinic office closed and telephone disconnected. Currently over 300 clients enrolled who have an access problem. Clinic has a main office and states that that's where clients should be referred. Other offices will see clients or services will be authorized. Lansing has been notified of this change.

Sponsor no longer working at an office and left no forwarding number.

Client is pregnant and attempted to get care at a hospital. Hospital attempted to reach the sponsor but number was disconnected. Clinic has been closed and doctor left no forwarding number hospital refused to treat client. Client was disenrolled and corrected Medicaid card was requested.

Clinic site is closed and client is ill and she does not have money to go to the other clinic that is still open. Disenrollment done.

Doctor listed on client's card has been out of the country for months. Client has been unable to find a new sponsor for herself and her child. Doctor's name still appears on client's card. Doctor is no longer in practice. Lansing notified. Client disenrolled.

Doctor has retired. Verified by telephone call to doctor's home. Doctor sent letter to all his patients. Office telephone disconnected. Information sent on to Lansing.

Dr. changed telephone number at a given site and dropped several sites.

Sponsor needs a billing number for another doctor but the doctor has left the location where the clients saw the doctor. This doctor had been working as an Internist but now specializes in gastrointestinal problems and works only out of hospitals. Lansing notified of this change.

Client gets service at a large clinic with several sites. She changed sponsors from a doctor at one site to a doctor at another site. She was refused service at the second site even though a doctor working there was listed as her sponsor on her Medicaid card. Sponsor Specialist worker called the site and was told that client has been going from clinic to clinic and that it is their policy that she get service at the clinic where most of her records are kept. Sponsor Specialist worker called the clinic to have this client's medical records transferred to the second site.

Client attempted to call her sponsor and was told number was disconnected. No further information was given. Client needs medical attention so Sponsor Specialist worker disenrolled the client and sent letter to doctor regarding 24 hour access.

Client has been enrolled with a sponsor for several months but had no need to see him until now. She was informed that this doctor was no longer taking new patients and would not see her. Client was disenrolled.

Client's doctor is no longer practicing at a given site. Determination needs to be made regarding this client and others enrolled with this sponsor.

Clients doctor died, retroactive. disenrollment done so client will get care.

Client called sponsor and was told he was no longer practicing. Sponsor Specialist worker called site and was told that sponsor had terminated one month prior. Patients were not notified but should be reassigned.

Client states she hasn't been able to locate her sponsor. The number on card has been changed. Sponsor Specialist worker called number on the sponsor list and was told number had been changed to a new number. New number was for a large clinic who claim that this doctor is not on their staff nor do they have any idea who he is. Client disenrolled from this sponsor and corrected Medicaid card requested. After further investigation it was found that this doctor's partner joined staff at large clinic and they closed their office but this doctor still practices out of another office. Sponsor Specialist supervisor informed doctor that Lansing should have been notified of office closure.

Client is a patient at community mental health services. He has been participating in Sponsor Plan since August 1985. The nurse at the mental health service has been attempting to arrange for the client to get a physical from his sponsor. The sponsor refuses to see the client because he has no picture identification. Nurse states there is little doubt that the client is who he says he is and that she has personally tried to arrange for the physical. The doctor states that picture identification is his policy without exception. Nurse from mental health clinic states that PPSP coupled with policies such as this doctor's are an exploitation of "Black People" and she wishes to register a formal complaint. She further asserts that many of her clients lack picture identification and are being denied medical care because of PPSP coupled with policies of doctor's such as this. Case referred to project director in Lansing.

Client's children have been enrolled with a sponsor since May 1986. When she tried to call to make an appointment for them, she was refused on the basis that this doctor is not taking any new Medicaid patients but that the doctor would be glad to make the necessary referrals to another doctor. Retroactive disenrollment done. Client will call when she obtains another sponsor for her children.

Children's sponsor no longer on staff at health center. Client does not know of another doctor to replace him with. Will call when she finds one.

A.P. worker gave this number to call regarding this problem. Recipient has a retired doctor on her card. Corrected card was requested but not received. Change was processed and corrected card requested.

Doctor has left his practice. Client disenrolled retroactively.

24 Hour Access

Client states she could not reach her sponsor. Sponsor Specialist worker called doctor's office and received recorded message stating doctor's office was closed and would be open at 1 p.m. the following day. Message could be left at beep and doctor would return call when possible. Letter regarding compliance with 24 hour access portion of contract.

Client states she attempted to call her sponsor regarding an infection, and let the phone ring 20 times. Doctor states he does not know what happened because his phone is always covered. When he is not at the office, calls are forwarded to his home, when he is not available there is a recording which gives the name and number of another physician. This is in compliance with the physician contract.

Client called doctor's office after office hours and got a taped message saying patient should leave a telephone number and someone would get back in contact with them. Client waited but then went to emergency room after not receiving a call back. Letter mailed to doctor from Sponsor Specialist worker regarding what is appropriate in regard to 24 hour coverage.

Client states she was told to go to the emergency room of a hospital when she called her sponsors 24 hour telephone number. Sponsor Specialist worker called hospital and was told by the assistant administrator that patients needing after hour medical advice or treatment were instructed to go to the hospital's emergency room. No triage is done over the phone. The hospital has eight satellites, some a considerable distance from the hospital. Copy of client's complaint sent to Lansing for determination of contract compliance.

Doctor could not be reached at number listed on Medicaid cards. Letter mailed to doctor regarding 24 hour access. The number on the card is the office telephone. The doctor's secretary called to explain that client's are provided with a card that lists the office number, answering service number and home phone. This information is also in the yellow pages. Doctor feels office number is more appropriate to have on the Medicaid card than the answering service number. Project Director explained appropriate 24 hour coverage and suggested either call forwarding or a tape hook-up which would provide the answering service number for after hours calls.

Attempt was made to reach physician. Sponsor number has been changed to another number which has been disconnected. Letter mailed to sponsor regarding 24 hour access provision.

Client could not contact her sponsor. Sponsor Specialist worker called and confirmed this. Letter sent regarding 24 hour coverage. Letter mailed to Sponsor Specialist worker from doctor which stated contract with the department will be terminated and because of increased malpractice insurance, the entire medical practice will discontinue.

Specialist doctor's staff could not reach sponsor at his 24 hour number to authorize treatment of two patients. Project director attempted to call and also could not get an answer. The doctor's office called project director for authorization and since she also received no answer she authorized one time visits for both patients.

Client with multiple medical problems called regarding access to her doctor. When Sponsor Specialist worker called the sponsor to discuss this matter he got a taped message stating the doctors hours and to leave a message and someone will call back as soon as possible. This is a 24 hr. access violation. Letter was sent to doctor regarding 24 hour access and client disenrolled from this sponsor.

Doctor requested removal of several clients from his caseload. Sponsor Specialist worker called to discuss this matter with him and could not get an answer. Letter regarding 24 hour access sent to the sponsor.

Client attempted to call sponsor to obtain a referral for care for her daughter. The 24 hour number listed on the clients card was for an answering service that the doctor no longer contracts with for coverage during non-office hours. Client does not want to change doctors, but, she wants to be able to reach him when necessary. In this case the clients daughter has fallen and has injured her foot or ankle and needs to see a doctor right away. It is not however life threatening and the client will not take her daughter to an emergency room as she is aware they will bill her. She is however unable to contact the child's sponsor and finally requested that her daughter be disenrolled so she may receive care. Retroactive disenrollment done. Letter was mailed to doctor regarding access.

Client claims she is not satisfied with her doctors treatment or mannerisms. She has taken her son to see another doctor but that doctor has not been paid. Sponsor Specialist worker called to the sponsors office was answered by an answering machine which took message and stated that doctor would call back. Letter mailed to doctor regarding 24 hour access.

Client went to see cardiologist but did not have authorization from her sponsor. Receptionist called sponsor and got a tape message to leave name and number. This is out of compliance. Letter mailed to doctor about 24 hour access. Client given authorization to see cardiologist by Sponsor Specialist supervisor.

Client called 24 hour number on card and was told by the answering service that her doctor no longer contracts with them. A call to the doctors office was made to find out about 24 hour compliance. Office manager stated she did not know what number should be on the card and would call back. Office number will be listed on Medicaid card and an after hours tape will give the doctor's home number and beeper number. One of these will be answered 24 hour a day.

Hospital staff member tried to contact a client's sponsor. Telephone number listed on Medicaid card is for an answering service. The doctor no longer contracts with this answering service. No other telephone number is listed for this doctor. Letter regarding 24 hour access provision sent to doctor.

Hospital staff trying to contact a doctor regarding authorization for treatment of a patient and have not been able to reach him. Letter mailed regarding 24 hour access after Sponsor Specialist worker could not contact sponsor at either site listed on the Sponsor list. Sponsor has closed one of his offices and has changed the telephone number at the other office. He states he notified Lansing of these changes. Sponsor Specialist supervisor called Lansing regarding the change in telephone number.

Client states she could not reach her sponsor. Sponsor Specialist worker called doctor's office and received recorded message stating doctor's office was closed and would be open 1 p.m. the following day. Message could be left at beep and doctor would return call when possible. Letter regarding compliance with 24 hour access portion of contract.

Hospital called 24 hour access number and got a tape machine telling the office hours and referring clients to the emergency room at a hospital. Authorization for treatment was given on a one time basis from Sponsor Specialist Unit. Recipient was told if she wanted to change doctors another name could be put on her Medicaid card. Letter was mailed to physician and he responded by telephone stating he would change his 24 hour arrangement to be in compliance with the contract.

Recipient says the doctor has poor access and they can hardly get in touch with him. Answering service was contacted and they state that the doctor went on vacation and did not notify them. That is why the telephone was not answered when the recipient tried to call.

Client states she has been trying to locate her sponsor for two months. The phone rings but no one answers. When she finally went to the office it was boarded up. Client was retroactively disenrolled since sponsor appears to have left practice. Letter regarding 24 hour access was sent to the doctor.

Client wants to see or at least talk to a doctor about her arm. She states her sponsor doctor has been out of town and has made no arrangement for a substitute. Sponsor Specialist workers tried to call the sponsor and got no answer. Client was disenrolled and advised that she could see another doctor who could call CIS to verify her Medicaid coverage. Letter regarding 24 hour access sent to the sponsor. Doctor later responded by phone and said he had been out of the country and that his receptionist was supposed to answer the phone during office hours and the answering service was to answer after hours. Doctor stated he was back now and there would be no further problem and apologized for any inconvenience caused.

Referral to Specialist/Second Opinion

Child was severely burned and has been receiving treatment at a hospital burn center. Family enrolled in an HMO and has been paying to have child continue treatment. Mother states she requested enrollment in the HMO because she thought the child could continue to go to the burn center. The HMO refused to authorize treatment at the burn center. Mother does not want to disenroll from HMO as she has been receiving prenatal care there and is due in January. Sponsor Specialist supervisor contacted administrator at the HMO and was told that in such instances the HMO honors past relationships with physicians. He stated the child could continue to get care at the burn center.

Client told by hospital staff where she was receiving pre-natal care that she would have to have her sponsors name removed from her card if she wants to continue to get care. Sponsor stated he had no problem authorizing the prenatal care, hospital was contacted regarding the referral and authorization process. Client was told there was no need to disenroll from her sponsor and she could continue to get the prenatal care.

Doctor refuses to give client authorization for a second opinion. Sponsor Specialist worker phoned doctor regarding this matter and was told by office manager that it is the doctors policy to deny second opinions and feels if a client wants to change it it is up to them. Office manager called worker back and stated that client can get authorization to see the doctor of her choice.

Client has a doctor on her card who speaks little English. Another doctor called to get authorization to treat the client's children but could not understand what the doctor said. Authorization given.

Clients sponsor doctor out of town. Doctor covering for him instructed client to go to the hospital for admission after discussion of her symptoms. Client was admitted. When her sponsor returned, he told client that all care could have been given on an outpatient basis. Sponsor did authorize tests and tests indicated possible need for surgery. Client claims doctor told her she is making trouble for him with the state by asking for referrals. She states he makes her feel like a cheat. She does however like the doctor and does not want to change.

Client seeking abortion but does not have referral. Clinic reached her sponsor but he did not have his I.D. number. Clinic worker called Sponsor Specialist worker to get the I.D. number.

Client unable to reach doctor for authorization to see an OB/GYN. Sponsor Specialist worker contacted doctor who stated it was his policy to see the patient first and if he could not handle treatment he would refer to a specialist. Worker explained that if client had a prior relationship with a specialist she was entitled to authorization from the sponsor.

Sponsor states that he made a referral to a doctor who performed an abortion on his patient which sponsor states was not authorized. This case was referred to Project Director for follow-up.

Client called stating needs immediate help. He has made arrangements to admit himself into a hospital for help with his dependency on alcohol and drugs. States he has been diagnosed as suicidal and depressed. Belongs to an HMO and they suggested that he go to an alcohol and drug counseling program that the client does not feel suits his condition. Client also told it would take 60 days to get out of the HMO. He states he has tried everything to speed up the process. Sponsor Specialist supervisor confirmed the process time. Client wanted the number of someone in Lansing. Lansing worker stated that a retroactive disenrollment could be done so client could be admitted into the hospital.

Client's daughter has been ill for about 4 months. The sponsor has been unable to resolve the problem and agreed to send daughter to hospital out-patient clinic. Hospital refuses to see her until the sponsor's name is removed from her card. Policy at hospital is that they will accept no Medicaid patients on a referral basis if they have sponsor who is not on the hospital staff, with only two exceptions; a OB problem beyond the scope of the sponsor; follow-up of patient seen in the Emergency Room of their hospital.

Client took her children to their eye doctor. She did not get authorization from her sponsor for the eye exam. The eye doctor called the sponsor to get the authorization, but the sponsor refused. The client called the sponsor and states that he said he did not want to treat any members of her family any more. Client wants to change sponsor and get payment for eye doctor. Sponsor Specialist worker called sponsor's office to verify client's story. Information was correct. Authorization is required as eye doctor is a specialist. Sponsor Specialist worker called sponsor and left a message, but sponsor did not return the call. The service is covered by Medicaid and the client has a long standing relationship with the specialist so authorization was given by Sponsor Specialist office. Children changed over to another sponsor.

Client states that doctor refused to refer her to a specialist. Sponsor Specialist worker called the doctor and he states that he refuses to give out his ID number to other doctors because they will use it for back billings. Doctor states he did refuse the client. Retroactive disenrollment done.

Client has been unable to get authorization take child to a nearby doctor despite lack of funds to take child to the hospital where the sponsor works. Client wishes to change doctors. Sponsor Specialist worker gave one time only authorization to see the doctor near the clients home until change is processed.

Unable to get a referral authorized because doctors line was constantly busy. Authorization was obtained after care was given.

Client lives in AFC home. Has difficulties getting referrals for psychological treatment because of name on her Medicaid card.

Doctor refused to refer client to an OB/GYN she has been going to for four years. The doctor wants her to go to an OB/GYN that he has an established referral relationship with. Sponsor Specialist worker called sponsor and explained PPSP contract. Sponsor then gave client his authorization to see the doctor of her choice.

Enrollment Errors or Questions

Client with Medicare and Medicaid states there are three mistakes on her Medicaid card, and incorrect address, the wrong date of birth, and the name of a doctor she never requested. Case sent to paper processing unit for identification of enrollment form.

Client states she did not sign up with the doctor on her card. She states she is satisfied with the hospital where her doctor works and has tests scheduled there next month. Sponsor Specialist worker requested a check of the enrollment form to see who signed it. Case referred to paper processing unit.

Client claims a doctors name is on her Medicaid card for her daughter and she never signed up for that doctor. Her daughter has sickle cell anemia and attends a specialty clinic. Sent to paper processing unit to check enrollment request. Also exemption from PPSP for this child is appropriate.

Client claims she was assigned to a doctor against her wishes. She also states she is not required to enroll in PPSP. Case sent to paper processing to check enrollment request. Client was disenrolled from PPSP since she was in a program code not required to enroll in the plan.

Client states she did not request the doctor on her card and states he is unknown to her and is located in a town she has no transportation to. She states she used to be in an HMO. Client was disenrolled and case was sent to paper processing unit to check enrollment form.

Client states she has taken her children to a clinic in the past. She did not request a doctor from the clinic to become her sponsor but a name appeared on her Medicaid card. She states she has not been to the doctor since getting the sponsor on her card because she didn't know what to do. She is pregnant and anxious to see a doctor she has been going to who is not affiliated with the clinic now listed on her card. Form referred to paper processing to check request form. Client disenrolled from the clinic doctor so she can get prenatal care from her doctor.

Client called to request change of sponsor for herself and her son. Change was made effective 3/1/86. During the week of 3/16 she received a letter stating that her previous sponsor was no longer participating in PPSP and that she was being assigned to another sponsor doctor if she did not agree to call Sponsor Specialist staff. She called the number and was told that everything was okay, and that the change had been made. When her next Medicaid card came the name that she was told would be assigned was on her card, not the name of the doctor she had chosen. Disenrollment done and form sent to paper processing unit for investigation.

Client states that the doctor she chose for her child did not appear on the Medicaid card but instead another doctor she had never seen was listed. Disenrollment done and form sent to paper processing unit for investigation.

Client called in a change on her Medicaid card last month for her children. This month the card came with another doctor that her children never saw listed on the card. Disenrollment done.

Client claims she filled out DSS form properly but when her Medicaid card came she was listed with her son's pediatrician and her son was listed with her doctor.

Children's pediatrician's name was put by her name and she was unable to see her own doctor without getting authorization. The client did not know how to change doctors until now. She sees an OB/GYN who is not a sponsor. Client will call back when she finds another doctor. She wants to keep seeing her present specialist when needed. The client does not know why the children's doctor was put on the card but it has been there since May 1985. Disenrollment from pediatrician done.

Client enrolled with pediatrician. Pediatrician claims the client is too old and wants to know how this client got enrolled. Received call from psychiatrist asking for authorization. The pediatrician would not provide authorization as he does not know of this client and she is too old to be one of his patients. Computer check shows all family members (mother and two children) are enrolled with this doctor. Enrollment form checked in Lansing and this doctor was requested for entire family. Client contacted by phone and she stated that a friend recommended that she enroll with this doctor and she did not know that he was a pediatrician. Client disenrolled and psychiatrist was contacted. No problem. Telephone call back to pediatrician and situation explained. Pediatrician was informed of how patients choose him. He had some concern about problems this causes but knows there is no way to prevent this.

Wrong name of doctor put on Medicaid card. One letter difference in the name. This prevented client from taking her sick child to the doctor. Disenrollment done and corrected card requested.

Pediatricians name on clients card. She is pregnant and due to deliver twins. Retroactive disenrollment done.

Client states that her doctor's office sent enrollment forms to Lansing six weeks ago. When the clients Medicaid card came name on it was unknown to the client. She spoke with Sponsor Specialist Unit supervisor regarding the problem. Disenrollment done and replacement card requested. Case referred to paper processing staff for enrollment request check.

Doctor on clients Medicaid card states he will not accept any new Medicaid patients. Client retroactively disenrolled.

Client enrolled with wrong doctor. Disenrollment done.

Client stated her husband was unable to get care because names were mixed up on Medicaid cards. Her son was listed with her husbands Internist and her husband with the pediatrician. Change made.

Client has pediatricians name on her card. She needs psychiatric care. Disenrollment done.

Client enrolled by mistake with her daughters pediatrician. Disenrollment done.

Client was disenrolled from PPSP due to high risk pregnancy so she could be treated at a hospital prenatal clinic. She had been enrolled with a doctor prior to her pregnancy who subsequently left his practice. Medicaid assigned the client to another doctor at the site where her doctor practiced. The client claims she does not know this other doctor, has never seen him, and does not want him as her sponsor. Client requests to continue to see the doctor at the prenatal clinic.

Client states her doctor is leaving his practice. She is due to deliver at the hospital where he worked. Doctor notified Lansing by letter that he would be leaving his practice and made no specific arrangements for his patients - his is letting them decide for themselves. Client will deliver at the hospital her doctor was affiliated with and then will choose another sponsor after delivery.

Client claims she signed up for her doctor an OB/GYN but when her Medicaid card came all her children were signed up with him too. Children were disenrolled from OB/GYN and enrolled with another physician.

Client on clinic plan when her case was closed. A misunderstanding involving workers in Lansing placed her in another clinic when her care re-opened. A correction will be made but client cannot go to the site she chose until the following month.

Client has a long standing relationship with a sponsor but was subsequently placed in HMO. She states this was done without approval and against her will. Since this client requested a doctor for her children who was not a sponsor but was affiliated with an HMO the entire family was enrolled with the HMO. The client does not want to wait the period for disenrollment stated by the HMO because she states it was not her error. She wants to see her sponsor for a scheduled appointment. Family was disenrolled.

Client's sons name did not appear on her "dental only" card so the dentist refused to see him. Sponsor Specialist worker contacted the HMO Unit in Lansing where a new Medicaid card will be printed. This will take about five days.

Client states she was enrolled in an HMO against her will. She requested a doctor who was not a sponsor for her children. Since this doctor was affiliated with an HMO the entire family was enrolled in that HMO. Client states she never intended to enroll her family there and requested disenrollment.

Client requested doctor at an office near her home. This doctor is also practicing at an HMO. Client and her family were enrolled in the HMO. Client does not wish to participate in an HMO, never signed forms and claims she never would have.

Error was made in Lansing when processing the form regarding the location of this doctors practice. Corrected Medicaid card mailed to client and family.

Client was placed in an HMO because she requested a doctor who was affiliated with it as her sponsor. Since signing the enrollment form the recipient has been placed in Recipient Monitoring. She states that having HMO on her card prevents her from obtaining needed medical care from her doctor. Case has since been closed but will be reinstated. Client has been assured that she would not be placed back on HMO at time of reinstatement.

Staff in Lansing did not process a change that had been requested by a client. Change should appear the following month.

Client has her child's pediatricians name on her Medicaid card as her sponsor also.

Client was enrolled with the pediatrician she requested for her child. Retroactive disenrollment done.

Client changed her sponsor last month. Her children were also changed to another doctor even though she did not request a change for the children. Children disenrolled and corrected Medicaid card was requested.

Client was previously enrolled with a sponsor. She attempted to enroll her son with a pediatrician. An error resulted in her being enrolled with the pediatrician and her son not being enrolled at all. Disenrolled client and requested corrected Medicaid card for her and her son.

Questionable Enrollment

Client called to complain that doctor who she did not request appeared on her Medicaid card. She went to the clinic where the doctor works for care about three weeks ago but stated that she signed no enrollment form at the clinic for that doctor. She is currently in a pre-natal program at a hospital which takes the place of having a sponsor. Her children are enrolled with pediatricians which wishes them to continue seeing. Client was disenrolled.

Client states she did not sign papers for the doctor on her card to become a sponsor for her family. She states she has always taken her children to a hospital for treatment and now cannot because of the name on the card. Computer shows this client was assigned and she did not request this doctor. Disenrollment done.

Client states she did not sign up with the doctor whose name is listed on her Medicaid card. Client disenrolled.

Client states that a representative from an HMO came to her house and stated that if she did not join her Medicaid, AFDC checks and food stamps would be cut off. She also stated that he told her that her doctor was not participating in the sponsor plan, although she had already signed up with him. The representative also asked the client to sign an HMO enrollment form, but she refused.

Client claims she went to a clinic but did not sign up with a sponsor there. She doesn't know how doctor's name got on her Medicaid card. Disenrollment requested.

Client claims she went to a doctor once but did not sign up with him as her sponsor. She wants him off her card. Disenrollment requested.

Clients has both Medicare and Medicaid and asked to have the doctors name taken off his Medicaid card. The following month the name was back on the card. Client disenrolled again.

Client states he went to the doctor listed on his Medicaid card once but never signed up with this doctor. The doctors name appeared on the clients Medicaid card and the client wants it removed. Disenrollment done.

Client filled out an enrollment form at her doctor's office for herself, but not for her children, yet the entire family was enrolled with this sponsor. Disenrollment done for children.

Client states she did not sign up with her OB/GYN as her sponsor yet his name is on her card. She likes this doctor and would remain with him if she could get referrals to her internist.

Client went in to see a doctor after being beaten up. Upon arriving at the doctors office for a second visit the client was told that he could not be seen by the doctor unless he signed an enrollment form for the doctor to become his Medicaid Sponsor. The client signed and made an appointment for himself and one for his son to get a physical exam required by his school. When the client and his son arrived at the doctors office they were told that the doctor was in court and the appointments would need to be rescheduled. The client rescheduled for himself but chose not to pull his son out of school for appointment. Client was told that the doctor has very rigid office hours since he is not only a physician but also a practicing attorney. Client states that patients are directed to the hospital emergency room if they need to see the doctor at other times.

Client was referred to a clinic by her sponsor for OB/GYN care. Client states she was informed that she would have to change to a sponsor at their clinic before a doctor would see her.

Doctor informed client that she would have to pay for services. Sponsor Specialist worker called doctors office and was told that the doctor will only see Medicaid patients if they have money to pay. Also stated that this doctor would not accept any new Medicaid patients.

Client claims his signature was forged on the PPSP enrollment form. He states he was asked to sign a form at the doctors office but refused to do so. Client states he does not have a regular doctor at this time but is in the process of looking for one.

Client did not sign an enrollment form for the children however a doctors name appears on the Medicaid card. She states she already has a pediatrician that she would choose for her children.

Client has both Medicare and Medicaid and asked to have the doctors name taken off his Medicaid card. The following month the name was back on the card. Client disenrolled again.

Client states she had been seeing her sponsor for 8 years but went to a clinic for an emergency. Her sponsor authorized the visit and the following month the doctor who treated her at the clinic was listed as her sponsor on her Medicaid card. Client very upset. Disenrolled and case sent to project director in Lansing for investigation.

Client states her worker told her if she did not fill out her enrollment form her case would be closed. Worker stated a date when form was due. Client states that she does not have a regular doctor for herself and her family at this time but expressed willingness to look for one. She stated she would phone back when she has identified a doctor to enroll with. Sponsor Specialist worker instructed client to write status and intention on form and return it to the local worker by the date requested. Copy of case mailed to project director in Lansing.

HMO

A woman who claimed to work for the state came to a clients house. She gained entrance to the home and asked to see the clients Medicaid card. The client showed the woman her card and she checked it against a list she had. When the client asked to see the woman's ID, the woman claimed it was in the trunk of her car. She then left. She was accompanied by another woman who came to the door but did not enter the house. This client is enrolled in PPSP.

Woman in the process of disenrolling from an HMO because she is pregnant and tried to make an appointment with an OB/GYN but was refused because she refused to consent to a blood transfusion if the need arose from anyone except her immediate family members. She gave several reasons for this, religious background, personal preference, fear of contracting infectious diseases, and never having been asked to sign such a consent form for bloodtransfusion in an out-patient clinic. She is three months pregnant and felt she should be under a doctors care. She went to another doctor, but will be personally liable for the bills as she cannot get out of the HMO until next month. Client feels early disenrollment should be possible to help her avoid debt. Sponsor Specialist worker phoned Lansing regarding the case and was told client will be disenrolled from the HMO the following month and that if she went to another doctor he would not be paid by Medicaid because he should not treat a client with a "dental only" card. Sponsor Specialist worker speculated that for all practical purposes client has been unable to receive care due to an in-house policy of this HMO, and by Lansing not requesting an early disenrollment for this client. Copy of the case was mailed to the HMO section in Lansing.

Clients two sons were in an auto accident. One was killed the other was hospitalized and then released. Client in an HMO but child was taken to a hospital emergency room for treatment. Client has been unable to get follow up care at the hospital even though she received verbal authorization from the HMO. Client has contacted both the HMO and the hospital and has been unable to get a resolution whereby her son can get medical care. Sponsor Specialist worker contacted a worker in the HMO section and requested they intervene. The client is grieving the loss of her son and does not appear to be functioning well according to the Sponsor Specialist worker.

Client states she was misled into joining two different HMO's. She wanted to join an HMO associated with a clinic near her home. The recipient thought any HMO would be taken at the clinic near her home. She said she was tricked into joining these other HMO's.

Client signed a disenrollment form from an HMO in May, client still on HMO. Telephone call to HMO unit shows that paperwork is done but not processed. Will be done immediately, client informed of this.

G.A.

Client with effective GA still PPSP. Disenrolled.

Recipient Monitoring

Client in Recipient Monitoring claims her district office does not know about the program. Client referred to Recipient Monitoring worker in Lansing.

Client called to change her sponsor but she was in the restricted to provider program and should not have had a sponsor listed on her card.

Doctor states one of his patients threatened to murder him because he would not prescribe narcotics. Copy of police report and letter requesting removal of client from caseload sent to the client. Retroactive disenrollment done.

Client in PPSP and on Prior Authorization. She is in fifth month of a high risk pregnancy and gets care at a hospital pre-natal clinic. Sponsor Specialist worker attempted to tell her that she was in PPSP in error and that she should contact her services worker to resolve the Prior Authorization problem. Client hung up in anger stating that by removing the sponsor (as worker stated would be done), she was being forced into Prior Authorization.

Client was not removed from PPSP when she was placed in Recipient Monitoring and has been in both programs for almost a year. She has continued to see her sponsor who is now refusing to see her due to non-payment. She claims to know nothing about Recipient Monitoring or to have been restricted to any doctor. Worker from Sponsor Specialist Unit asked her to contact the services worker who has restricted her case. She will be disenrolled from PPSP and a corrected Medicaid card will be requested.

Client enrolled in PPSP and Recipient Monitoring. Client's sponsor unable to receive payment for 15 months. Sponsor Specialist supervisor asked doctor to send invoices to her and she would have payment forced.

Misinformation

Client in CAP received letter stating she must sign up in one of the three case management options or the Medicaid Enrollment Unit would assign her a doctor. This client is also Medicare eligible and is not required to participate. Sponsor Specialist worker instructed client to disregard the letter.

Client's young daughter received a letter stating she had to pick a health care plan or be assigned to a doctor. Client informed to disregard the letter but that a choice would have to be made. Client mailed a copy of the three plan booklet.

Client with Medicare and Medicaid received a letter stating he was required to pick one of the three health options or have a doctor selected for him. Client was instructed to ignore the letter and told that he is not required to enroll in a plan.

Nine year old child received letter stating she would be assigned a doctor if she did not select one of the three health care options by a given date.

Client's son is under the care of an epilepsy specialist and has been for nearly fifteen years. This specialist is the only doctor her son has ever had and must continue to see him. Client states her son received a letter stating he must sign up with a health care plan or be assigned. Client very upset. Sponsor Specialist worker assured client that an assignment would not be made on the day stated in the letter. Client was instructed to fill out the form and put the specialists name and address on the form.

Physician Requested Client Disenrollment

Doctor called to remove twenty nine patients from his caseload. He informed them by letter of this decision.

Sponsor states family has requested to be removed from his caseload. Disenrollment done. Letter sent to family requesting they choose another sponsor as telephone has been disconnected.

Doctor sent letters and stated he wanted certain recipients disenrolled from his caseload but does not indicate why or whether he informed them. Sponsor Specialist worker stated this information must be included in his request. The doctor stated he would do this and provided information on the clients. Clients disenrolled and letter sent to clients.

Doctor wants client removed from his caseload as client will not follow his instructions for care.

Six doctors called to have patients removed from their caseloads.

Doctor states he wants a client removed from his caseload because she required more psychiatric care and medications than normal. Since she is seen more by the psychiatrist than by the sponsor and so many referrals had to be made, the doctor feels she is a big burden to him. The sponsor agreed to carry her through as his patient for the rest of the month. After that, he will no longer be listed on her Medicaid card, but he will see her if it is necessary. Client disenrolled.

Office manager called and stated client was ingesting too much medication and they did not want to carry her as a patient any longer. Recipient was informed of the action by the sponsor via letter. Client was disenrolled and letter was sent to her asking her to make another primary sponsor choice.

Pharmacy

Client wishes to formally complain that pharmacy is continuing to collect the 50¢ co-pay on her mother's prescriptions. This runs from \$3.50 - \$6.50 per month. This is client's second complaint on this matter. Sponsor Specialist worker states that in previous conversation pharmacy personnel state a directive was received from the Department of Social Services authorizing that the waiving of the co-pay for PPSP participants has been superceded. Client wants a full refund. Sent to project director for follow-up on directive. Once information is obtained, Sponsor Specialist workers will be notified.

Pharmacy at hospital has been charging 50¢ co-pay on prescriptions even though client is participating in PPSP. Sponsor Specialist worker called pharmacy and explained waiving of co-pay to pharmacist.

Pharmacy not in Wayne County. Client has been charged co-pay on scripts even with sponsor's name on card. Pharmacy contacted and issue resolved.

Billing Problems Client

Client billed for emergency room treatment on final diagnosis not on presenting symptoms. Hospital will rebill.

Client billed for care received in 1984. Billing department at hospital states bill is too old. Client advised to request a hearing.

Client did not receive Medicaid card and doctor stated she would have to pay for care. Client was covered by Medicaid at the time and bill will be re-submitted.

Client went to emergency room because of chest pains and difficulty breathing. Client billed for care. Sponsor Specialist worker called hospital to check on this and was told that they have been informed emergency room usage for chest pains would no longer be paid for. Supervisor did approve rebilling. Result of rebilling not known. Case pending resolution.

Pharmacy charged client 50¢ co-pay on all prescriptions written by doctors who were not her sponsor. Pharmacy worker stated they believed that was the policy they were to follow. Pharmacy worker spoke to Sponsor Specialist supervisor to clear up this billing problem with the pharmacy.

Client being threatened by collection agency from hospital for operation. Medicaid stated they would not pay. Client advised to appeal decision.

Daughter in accident. Mother received bill from hospital. Daughter now in extended care facility. Sponsor Specialist worker checked into case, insurance company responsible for bill, not Medicaid or mother.

Clients doctor has joined the staff at an HMO. Prior to this he authorized surgery for her. Client went to hospital for evaluation in January and was told she should wait until June for surgery. Client waited and had surgery, remained in hospital for five days. Doctor who was her sponsor at the time but now on HMO staff denies he made referral. Dept. of Surgery at hospital has proof and contacted doctor who stated he would send necessary forms so hospital can get paid.

Child in auto accident which resulted in her death one month later. Bill received by family for hospital care. Sponsor Specialist worker unable at this time to find out particulars on Medicaid billing rejection, but will investigate.

Client billed for care on final diagnosis, not on presenting symptoms. Worker from Sponsor Specialist Unit informed hospital worker that billing should be done on presenting symptoms.

Client received bill for emergency care because the staff stated that the presenting symptoms were not of an emergency nature. Client was diagnosed as having meningitis. Sponsor authorized treatment and client was hospitalized. Billing was forced by Medicaid.

Client suffering severe abdominal cramps and believed she was having a miscarriage. A friend of the clients called the sponsor number on the Medicaid card. A tape recording instructed them in case of emergency to go to the emergency room of the hospital where the doctor is on staff. The clients friend drove her to the hospital where she was treated in the emergency room. Client believes Medicaid should pay since tape instructed her to go to emergency room and she felt it was an emergency. Call made to sponsor office indicates office hours and states that in an emergency clients should go to the emergency room. Doctor was mailed a letter regarding compliance with 24 hour access provision of the contract. Attempt will be made to force payment of the client's bill.

Client being billed for emergency room care. Client's child was having difficulty breathing. She called the sponsor's office and was told that the office was closed. Billing department at hospital rejected the bill based on non-emergent diagnosis. Client was mistaken about the billing date according to billing department. Time period has run out and bill has been turned over to a collection agency. Hospital states they will take care of the matter and client will receive no more bills.

Client has received two bills from a hospital. States she could not stand upright and her doctor was not in the office. She went to an emergency room. Billing office states it was not an emergency and that client reported having symptoms two weeks prior to going to emergency room. Sponsor Specialist worker informed client that she could file for a hearing to appeal Medicaid's decision. Client appeared to be hesitant about contesting the decision although she states she felt the condition that led her to the emergency room was an emergency. She states she had several operations, exploratory surgery and a complete hysterectomy. She states she has pain that won't go away.

Billing (Provider)

Bill submitted six times and each time it was rejected. Caller referred to Provider Hot-line.

Number for doctor has been disconnected and doctor is no longer in practice. Bill has been rejected for inadequate information. Sponsor specialist worker provided ID number.

Medical Appropriateness

Client and her family enrolled with a large clinic at their neighborhood site. Client reports that the staff at the clinic told her she was required to send her children to another one of their sites for EPSDT screening. The penalty for not doing so would be termination of Medicaid benefits. Sponsor specialist worker informed client that the screening is not mandatory and she would not be cut off from Medicaid if she did not comply. Referred to Project Director for review and follow-up.

Client states she has a heart condition and needs to see a specialist at a hospital clinic. Clinic will not see her because there is a name on her card. A call to sponsor's office states that authorization will be given for this month but a letter will also be sent requesting disenrollment of this client.

Client called stating she was hooked on a pain killer because of her sponsor. She also stated that she had a slight stroke and asked her sponsor to refer her to a specialist she had seen before and the sponsor refused. Client states she was advised by her attorney to call the Sponsor Specialist Unit. Worker referred her case to the Project Director in Lansing for further investigation.

Doctor states she will not see a client because Medicaid has not reimbursed her for visits when another doctor was her sponsor. Sponsor Specialist worker phoned doctor's office regarding unpaid bill. Doctor states payment for 3 visits was not received. Client did not produce Medicaid card according to the doctor. Client denies this and states she showed her current card at each visit. Doctor states she wants client and her family removed from her caseload. Retroactive disenrollment done. Copy of case sent to project director in Lansing.

OB/GYN refuses to see pregnant client until her sponsor name is removed from her card despite written authorization from her sponsor. Client says doctor told her to either get a card without anyone's name on it or have his name put on it before she can continue under his care. Worker from Sponsor Specialist Unit phoned doctor's office and left message. Doctor's office returned call and stated doctor would continue to see client with her sponsor's authorization. Sponsor Specialist worker informed the doctor's representative that client had been disenrolled from her sponsor and enrolled with the OB/GYN and suggested she call CIS to verify. Copy of case forwarded to project director in Lansing.

Sponsor Specialist Office Complaint

Client wants to work at Sponsor Specialist Unit to help staff answer the telephones that always are busy.

Exceptions

Client has multiple physical problems and has had difficulty getting medical care because of the sponsor's name on her card. Rehabilitation center refused to see the client with the card the way it is. Client disenrolled from PPSP and new Medicaid card requested.

Client is an elderly woman who wants to see a doctor at a specific hospital as her sponsor. This hospital will not take new Medicaid patients unless clients join the HMO connected with the hospital. Client is on SSI and due to her age, she was disenrolled from PPSP.

Client has sickle-cell anemia.

Client has multiple medical problems and must see a specialist. Has liver condition, anemia, arthritis and gets blood transfusions monthly. Client's sponsor is tired of authorizing care. Client gets all care from one physician who is not a sponsor. Marketing will be done to this physician.

Client has multiple medical problems including liver disease. He is in and out of the hospital. Client has been exempt from PPSP due to multiple medical problems.

Client has multiple health problems and recently had two strokes. Her doctor recommended that she no longer participate in the sponsor plan.

Client in an institution enrolled in sponsor plan. Disenrollment done.

Medicare

Client on Medicare and Medicaid. Does not want to participate in PPSP. Disenrollment done.

Client's doctor is no longer a sponsor. She is elderly and does not want to change doctors. Client does not want to participate in Sponsor Plan if her doctor can no longer treat her. Client disenrolled.

Foster Care

Calls were received from protective service workers regarding twenty-one children who had been enrolled in the Sponsor Plan.

Two children in foster care were signed up in PPSP. Retroactive disenrollment done but there are outstanding bills.

Dental

Two clients state they were unable to see the dentist because they had a sponsor's name on their Medicaid card.

Dental clinic refused to see client because she had a sponsor's name on her card. Problem resolved after Sponsor Specialist worker spoke with clinic manager who stated that personnel at front desk misunderstood client.

Moved Out of County

Moved out of Wayne County yet sponsor name still appears on client's Medicaid card (29).

Client's son still has sponsor listed on Medicaid card even though family moved out of Wayne County. Son was denied medical service and prescriptions were paid for in cash because PPSP was unknown to providers in this county. Client was disenrolled and a corrected Medicaid card was requested.

Inquiries from Encounter Records
(*Indeterminate Sample)

Client

Request for information on three options	(419)
Request for enrollment information	(185)
Request for change of provider	(67)
Recipient unable to identify replacement sponsor	(42)
Request for doctors who are no longer sponsor or never have been	(77)
Request for information on referrals/second opinions	(99)
Information on Medicaid cards that were lost, stolen or never received	(80)
Request for doctor in specific zip code	(54)
Billing inquiries	(49)
Client in restricted program	(65)
General Medicaid information requests	(161)
Non-Medicaid information	(29)
Client does not want a sponsor	(21)
Information on letter regarding PPSP	(21)
Other insurance listed on Medicaid card	(14)
Medicare and Medicaid	(10)
Dissatisfaction with care	(9)
Enrollment error	(5)
Sponsor will accept no new Medicaid patients yet listed on clients' card	(4)
Exemption request	(4)
Request for information booklet	(5)
Moved out of county	(3)
Difficulty contacting sponsor	(3)
Pharmacy inquiry	(3)
Questionable enrollment procedure	(3)

CAP

Client's son needs to see a psychiatrist. Belongs to CAP. Informed by psychiatrists office that they will not accept Medicaid. Sponsor Specialist worker called Lansing, psychiatrist is also part of CAP. Worker called client with instructions on how to make the appointment with the psychiatrist. There was misunderstanding regarding straight Medicaid vs. clinic plan enrollee.

Client went to hospital Emergency Room and was hospitalized for a couple of days. She received a bill for \$1,302.00 and billing department of hospital states that they had no record of client's medical insurance. A phone call to Lansing revealed that hospitalization should be billed to Medicaid and doctor's fee should be billed to the CAP. Instructions for billing given to hospital personnel. Resolution is pending for payment by Medicaid and CAP for hospitalization and doctor.

Systems Problems

C.I.S. gave wrong doctor's name for billing.

C.I.S. refused to check billing dates because they stated they were too old.

Hearing Request

Client wants off PPSP and states she does not want any sponsor on her card. All members of the family are signed up with the same sponsor. One of her children had a hearing problem that the sponsor failed to treat properly and the child had to have surgery because of this. Sponsor Specialist supervisor explained the program to the client but she adamantly refuses to change to another sponsor. She just wants out of the program. She wants to go to any doctor she chooses when she feels it is necessary. She feels all sponsor doctors are incompetent. Prior to PPSP her children saw two pediatricians, neither of which is now or ever will participate in sponsor program. Client refuses to understand case management. Offered client time to choose a new sponsor but she states she never wants a sponsor. Supervisor gave the client her name and number in case she had need for further discussion. Explained that saw no way to resolve this given her stance. Advised her that there would be a hearing. Supervisor called hearing coordinator and advised her of the case. Coordinator states she will need a legal base for mandatory nature of the program. This is available from project director in Lansing.

Client does not want her sponsor. She cannot find another doctor she is willing to put on her Medicaid card. Her friend does not have a sponsor on her card. Client does not have a published telephone number. Sponsor Specialist supervisor called hearing coordinator to inform her of case and set up a pre-hearing conference. Contacted worker and asked to have this set up. Worker states she will have the client call. Client has not called as of this writing. Case referred back to hearing coordinator.

Other

Verification of sponsor	(5)
Billing information	(5)
Foster Care disenrollment	(4)
DSS worker inquiries	(4)
Non-Wayne county billing procedure	(2)
Hospital requested authorizations	(2)

*The numbers associated with these entries represent various degrees of sample size and representative types of telephone encounters. Based on the experience and time constraints of staff persons involved, certain classes of inquiries are not documented at all times.

Sponsor Specialist line busy (2)

Sponsor

Inquiries regarding billing (15)

Verification of sponsor (16)

Sponsor changing location or closing office (15)

Wrong number listed for sponsor (12)

Request for forms/booklets (11)

Eligibility (7)

Request to enroll as sponsor (4)

Procedural information (4)

Recipient Monitoring (4)

Authorization (3)

Termination of contract (3)

No new Medicaid accepted (3)

Referral procedure inquiries (3)

Inability to contact another sponsor (2)

Contract information (2)

Information regarding covered services (2)

EPSDT information requested (2)

Medicaid Hot-line request (2)

Non PPSP information (2)

24 hour compliance response (2)

Physician requested client disenrollment (2)

Refusal to perform certain Medicaid covered procedures (1)

Non-Wayne county doctor inquiry for PPSP billing procedure (1)

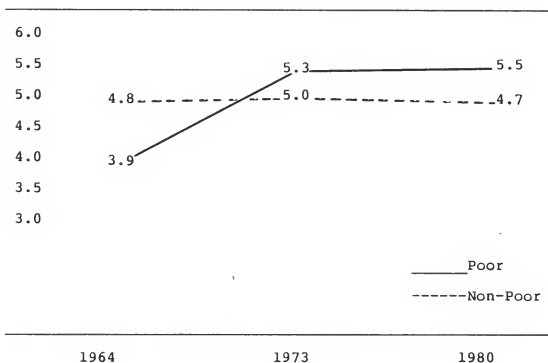
APPENDIX C

SUMMARY OF PRIOR RESEARCH ON ACCESS AND SATISFACTION

Previous Research on National and Michigan
Utilization Patterns and Access to Care

In general the review of national and Michigan utilization patterns suggests a higher usage of prescriptions and hospital services by Michigan Medicaid recipients than the national average. A University of Michigan study also reported longer average length of stays in hospitals for Medicaid recipients. (Griffith, 1981). The concept of the poor using more health services is also supported by documentation of the Robert Wood Johnson Foundation. As shown in Figure I-1, there was an increase in the use of physician visits for the poor versus the non-poor from 1964 to 1980.

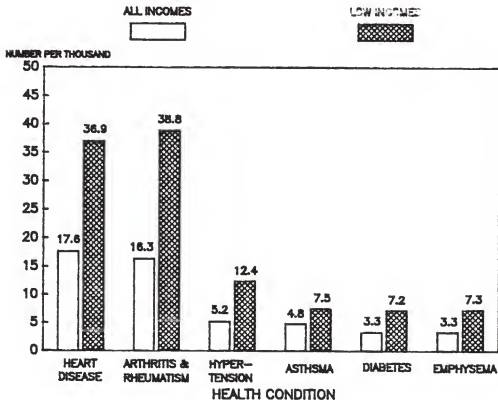
FIGURE I-1
Per Person Physician Visits:
Poor and Non-Poor 1964-1980



An explanation for the increased use of health care services by the poor and Medicaid recipients is a greater prevalence of serious chronic health conditions. These conditions may result from nutritional deficiencies, less understanding of medical problems and preventive practices, and more stress and tension from living on marginal resources. Figure I-2 profiles the differences in the prevalence of chronic health conditions by income: The poor have twice the incidence of these diseases than the non-poor. These conditions, however, only exist for 4% or less of either population.

FIGURE I-2

Prevalence of Serious Chronic Health Conditions by Income



However, this factor alone does not explain the increased use of health services by Medicaid recipients. The reasons are numerous, and probably inter-related. The effect of the many variables outlined in the introduction to this section is unknown at this time.

C. Access to Care

The increased use of health care services by the poor is probably due to increased access to these services. Access to care has dimensions. These will be reviewed in terms of how Medicaid recipients compare with other users of these services in general, they compare favorably.

There are at least five dimensions to access to care:

- o The patient has a regular source of care.

It is assumed that obtaining primary care from a regular source is better than seeking different sources for each illness. Treatment by the same physician on a regular basis is also assumed to be an indicator of better access.

- o Care is available when needed.

It is assumed that care should be available when needed and, ideally, on a 24-hour basis by the same regular source of care.

- o Travel time to the site of care should be reasonable.
- o Length of time to obtain an appointment to receive care should be reasonable.

- o Waiting time at the site of care should be reasonable.

There is considerable national research on these dimensions of access to care. If reasonable is defined as equal for all patients (Medicaid and non-Medicaid), then this national data is very informative. Tables I-8-12 are drawn from the National Health Care Expenditure Study.

1. Regular Source of Care

Table I-8 shows that only 14.2% of the national population and 15% of the Medicaid population reported that they do not have a usual source of medical care. The percent of U.S. population with a usual source of care has remained relatively stable over time (85.8% in 1977; 88% in 1976; 89% in 1970; 87% in 1963).

Of the U.S. population, 66% indicated that their usual source of care is provided at a physician's office. Only 52% of Medicaid recipients indicated they receive care at a physician's office. They were more likely to receive their usual source of care at a health center or hospital outpatient department.

Those whose usual source of care is a physician's office are more likely to see the same physician. This appears to be true for both Medicaid and non-Medicaid patients. However, if the site is other than a physician's office, the patient is more likely not to see the same physician. This seems to be more true of Medicaid recipients and the uninsured than others.

Table I-9 shows that of those who do not have a regular source of care,, more report that they do not get sick. This percentage was somewhat smaller for Medicaid recipients (60%) than for the general population (65%).

2. Availability

Table I-10 details the availability of services outside of regular office hours. This table does not display the data by Medicaid versus non-Medicaid recipients. However, access to care appears to be more readily available for patients receiving care at hospital outpatient departments, emergency rooms, health centers and clinics. These are more likely to be the regular sources of care for Medicaid recipients.

3. Travel Time

Table I-11 shows that 80.8% of the population reported traveling less than 30 minutes to their usual source of care. Medicaid, Medicare, and uninsured patients reported longer travel time to receive care. However, no more than 26% of any group reported travel times that exceeded 30 minutes.

4. Appointment Wait

Table I-12 provides information on the average length of time to obtain an appointment for health care service. This data was drawn from a national study by the Center for Health Administration Studies and the National Opinion Research Center (CHAS-NORC) in 1976. It showed a national average of 64% obtaining an appointment within two days.

Two surveys of Wayne County Medicaid recipients have recently been completed. Table I-12 includes data from those surveys indicating that HMO recipients must wait longer for appointments.

5. Waiting Time

Table I-12 also reflects information on the waiting time at the site of care. It shows that 64% of the national sample waited less than 30 minutes. The Wayne County sample indicated a lower percent waiting less than 30 minutes.

The data suggest that in comparison to the general population the Medicaid recipient has similar access to a regular source of care. However, the source is more likely to be a site other than a physician's office. This results in less likelihood of seeing the same physician each time; more access to care outside of regular office hours; greater travel time to receive care; similar waiting time to receive an appointment; and longer waiting time once having arrived at the site of care.

TABLE I-8
Usual Sources of Care (1977)

Population Characteristics	Total Population	No Usual Source	Usual Source of Care				
			Physician's Office	Hospital Outpatient Department	Emergency Room	Health Center & Other	Don't Know No Answer
Total	212,822,000	14.2%	65.7%	4.8%	1.0%	5.1%	9.2%
Insurance Coverage							
• Private	170,369,000	13.3%	69.8%	3.0%	0.8%	4.0%	9.1%
• Medicare	24,122,000	10.8%	70.6%	5.7%	0.7%	4.0%	8.2%
• Medicaid	22,752,000	15.0%	52.2%	9.6%	2.3%	10.3%	10.6%
• Uninsured all Year	16,569,000	24.8%	51.5%	6.4%	1.4%	6.1%	9.8%

• NCHR National Health Care Expenditure Study, "Usual Sources of Medical Care and Their Characteristics", Data Preview 12, October 1982. Table 1

TABLE I-9
Reasons for Having No Usual Source of Care (1977)

Population Characteristics	Population Without a Usual Source of Care	No Usual Source of Care Because				
		Does Not Get Sick	New To Area	Source No Longer Available	Goes to Different Places	Other, No Reason
Total	30,289,000	65.4%	18.8%	12.4%	21.3%	12.7%
Insurance Coverage						
• Private	22,589,000	64.7%	19.1%	12.9%	23.3%	11.8%
• Medicare	2,596,000	67.4%	7.8%	20.2%	13.0%	13.4%
• Medicaid	3,403,000	60.0%	20.2%	11.6%	18.7%	17.5%
• Uninsured all Year	4,112,000	69.9%	17.8%	9.1%	15.7%	15.7%

- Percents add to more than 100 because a person may have more than one reason.
- NCHR National Health Care Expenditure Study, "Usual Sources of Medical Care and Their Characteristics", Data Preview 12, October 1982. Table 2

TABLE I-10

Availability of Services Outside Office Hours (1977)

Type of Usual Source of Care	Type of Service				
	Emergency Treat- ment After Office Hours	Regular Evening Hours	Regular Saturday Hours	House Calls	None Outside of Office Hours
Physician Office	70.0%	20.6%	48.2%	17.7%	13.4%
Other ¹	71.3%	30.9%	42.8%	6.7%	8.0%

¹ Other includes hospital outpatient department, emergency room, health center, company/industry clinic, patient's home or other site.

NCHSR National Health Care Expenditure Study "Usual Sources of Medical Care and Their Characteristics", Data Preview 12.

TABLE I-11
Travel Times to Usual Sources of Care (1977)

Population Characteristics	Total Population	Travel Time				Dissatisfied When Travel Was	
		Less Than 10 Minutes	10-29 Minutes	30-59 Minutes	60 Minutes or Longer	Less Than 30 Minutes	30 Minutes or Longer
Total	163,446,000 ¹	20.6%	60.2%	15.3%	3.9%	2.2%	22.2%
Insurance Coverage							
• Private	132,614,000	21.6%	60.5%	14.4%	3.4%	2.2%	20.9%
• Medicare	19,601,000	15.8%	59.7%	18.5%	6.0%	1.9%	19.6%
• Medicaid	17,109,000	16.0%	58.2%	19.4%	6.3%	2.4%	28.1%
• Uninsured	10,945,000	16.4%	60.1%	18.2%	5.3%	1.9%	24.5%

¹ This excludes persons who had no usual source or did not answer question about source or about travel time to usual source.

TABLE I-12
Travel, Appointment and Waiting Times

	CHAS- NORC ^a		FFS ^c		PPSP		HMO
	PHRED ^b		BASE	EXP	BASE	EXP	
Travel Time < 15 minutes ^c	48.0%	32.1%	36.2%	36.2%	36.1%	37.5%	27.5%
Appointment Wait < 2 days	64.0%	51.5%	64.3%	59.2%	63.2%	63.2%	25.3%
Office Wait < 30 minutes	64.0%	53.3%	54.1%	56.0%	51.6%	53.8%	55.3%

^aCenter for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), 1976.

^bPrepaid Health Research, Evaluation, and Development Project (PHRED), California State Department of Health Services, 1979.

^cFor the national sample, this is the percentage traveling less than 15 minutes, so the actual difference is understated in this comparison.

TABLE I-13
Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
Patient/Personal Satisfaction With Medical Care, February, 1957.	To determine satisfaction with medical care in relation to the variables influencing it.	Q/checklist completed by patients/staff in 60 hospitals.	General -including both patients and professional staff.	Inpatient Hospital Care	- Physical Environment - Technical Quality - Art of Care	1. Older patients more satisfied. 2. More hours of professional care related to higher satisfaction.
Patient Participation In a Pediatric Program, 1960.	To discover relationships between family characteristics, mothers conception of herself, and the child's participation in the program.	Q/in home face-to-face interview.	Mothers of young children.	Outpatient Clinic - Treating rheumatic fever patients.	- Art of Care - Accessibility - Finances - Technical Quality	1. Good participation related to identification with clinic, belief in staff rather than mythical or poor understanding. 2. Poor participation related to family problems, poor self concept.
Attitudes/Medical Practices of Parents Towards Mass T.B. Testing Program, May 1963.	To analyze the family and their attitudinal characteristics relating to a free medical service.	Q/face-to-face interview of sample of parents who did participate, who refused, or refused but had the test done privately.	General	Department of Public Health T.B. Testing Program in Schools.	- Art of Care - Outcomes/Efficacy - Access/Convenience - Finances	1. Non-participants had fears of medical care, poor knowledge of illness (T.B.). 2. Refusers who had it done privately were highly educated high income group.
Mothers Opinions of Their Pediatric Care, January, 1965.	To determine what dimensions in satisfaction with medical care are most important to least important.	Q/mailed to 56, face-to-face to 81, all forms treated the same in the analysis.	Mothers of young children	Outpatient Pediatric Clinic in Hospital	- Art of Care - Access/Convenience - Technical Quality - Finances	1. 98% satisfaction with Art of Care/Tech.Qual. somewhat less satisfied with facilities & administration. 2. Dimensions most important Art of Care/Tech.Qual. (most) Fees/Facilities (least).

*Q under "Methodology" refers to questionnaire.

TABLE I-13 (continued)
Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
The Health and Attitudes of People Who Seldom Consult A Doctor, 1965.	To compare characteristics of people who see a doctor regularly to those who seldom or never consult a physician.	Q/face-to-face interview. Groups classified as "attenders" (less than 2 years since last appt.) and non-attenders (from 2 to 10 years since last appt.).	General	Sample of one doctor's private practice.	- Art of Care - Technical Quality	1. Non-attenders saw themselves as healthier (most important factor). 2. Non-attenders more critical of doctors. 3. Non-attenders more apt to be male.
Consumer Satisfaction With Group Practice, The Cha Case, November 1967.	To determine the extent of satisfaction with group practice prepayment plans.	Q/telephone interviews by professional staff, with 489 usable forms from sample.	UAW members and families in Detroit, Michigan	Group Practice Plan	- Physical Environment - Art of Care/Tech. Quality - Accessibility	1. 78% "like it a lot" after 3 years. Only 45% liked it at the beginning. 2. Single persons least satisfied, those with children liked it most. 3. Blacks generally more satisfied.
Gaps in Doctor/Patient Communication November, 1968. (1st article).	To determine the relationships between doctor/patient communication and outcome in terms of satisfaction and response to medical advice.	Q/2 face-to-face interviews - 1st after visit, 2nd 14 days later for patients and 64 different physicians.	Mothers of young children	Walk-in Clinic, Emergency Room in Hospital	- Art of Care - Technical Quality - Access/Convenience - Outcomes/Efficacy	1. 76% of visits resulted in high to moderately high satisfaction. 2. Very little difference as it related to demographics. 3. High satisfaction but obvious problems exist in communication between doctor and patient.

*Q under "Methodology" refers to questionnaire.

TABLE I-13 (continued)
Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
Gaps in Doctor/ Patient Communication March, 1969. (2nd Article)	To test hypothesis that attributes of the inter- action influence the out- come in terms of compliance.	Same as Above (800 patient interviews)	Same as Above	Same as Above	Same as Above	<ol style="list-style-type: none"> 1. 80% high to moderately high compliance with regimen. 2. If doctor perceived as unfriendly - lower compliance. 3. High satisfaction = high compliance. High dissatisfaction = low compliance.
"Determinations of Medical Care Utilization". Failure to Keep Appointments. June, 1973.	To investigate the dimension of the problem of appointment failures and to analyze causes.	Data Gathered from 5% sample of urban area, 6,500 patient records. Type of service - provider - symptoms, nature of care, etc.	Recorded appointment failures of two groups: 1. No show with no call. 2. Same day cancellations.	Pre-paid health plan - general population	- Access/Convenience - Continuity of Care	<ol style="list-style-type: none"> 1. Twice as many poor patients failed to keep appointments. 2. Younger patients had a higher rate of appointment failure. 3. 16% of all appointments ended in appointment failure.
"Patients Perceptions of Hospital Care" April, 1972	To examine three things: 1. Patients perception of care. 2. Patients understanding of problem. 3. Effect of these perceptions on outcome of hospitalization.	Q/284 patients, in-home - face-to-face interview 7 days after discharge.	General	Inpatient Hospital Setting	- Art of Care - Technical Quality - Access/Convenience - Finances - Physical Environment - Outcomes	<ol style="list-style-type: none"> 1. 98% satisfied with care from nurses/doctor. 2. 83% believed their condition had been improved. 3. Less satisfied with facilities - admission practice, food, etc.

*Q under "Methodology" refers to questionnaire

TABLE I-13 (continued)

Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
The Distribution of Medical Services Before and After Free Medical Care. November, 1973.	To determine changes in medical service usage in general population before/after the implementation of Medicare.	Q/two household surveys - before and after implementation of Medicare. 6,000 units in 1st. ½ that in 2nd.	General Population in Quebec, Canada.	General Medical Services in large urban area.	- Availability - Art of Care - Access/Convenience - Finances	1. Lower socio-economic groups had significant increase in visits. 2. Waiting time for appointment went from 6.0 to 11.0 days. 3. 8% felt medical care was better since implementation, 30% felt it was worse.
"A New Approach to Explaining Sick Role Behavior in Low Income Populations" March, 1974.	To test a behavioral model of compliance including: perception of disease, severity of disease, outcomes in relation to prevention.	Q/face-to-face 1 hour interview of 125 random sample.	Mothers of young children suffering from ear infections. All but 3 mothers were black.	Clinic in large hospital - outpatient.	- Art of Care - Technical Quality - Outcomes/Efficacy - Continuity	Non-compliers were: 1. Not concerned about health. 2. Sees child as healthy. 3. Feels not necessary to follow medical advice. 4. Generally skeptical of doctor and medication.
Variables in Patient Satisfaction With Medical Care. December, 1975.	To determine levels of satisfaction with a university health service.	Q/self-administered after visit of 10% random sample of students.	University Students Male/Female	University Health Service - Both inpatient and clinic outpatient services.	- Art of Care - Technical Quality - Access/Convenience - Outcomes/Efficacy	1. 56% generally satisfied. 2. 28% neutral. 3. Art of Care most important factor in satisfaction. 4. Women significantly less satisfied than men.

*Q under "Methodology" refers to questionnaire.

TABLE I-13 (continued)

Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
"Consumer Satisfaction With Prepaid Group Practice: A Comparative Study". 1975	To compare patient satisfaction in two separate health plans, prepaid group practice, and a traditional fee-for-service Blue Cross plan.	Q/face-to-face household interviews. Pre-paid N = 356 Traditional N=354	Skilled/Semi-skilled blue collar workers, + a second group of white collar workers.	General Medical services in large urban area.	- Access/Convenience - Finances - Continuity - Availability	1. Both groups indicated a high level of satisfaction. 2. Blue Cross (traditional plan) significantly more satisfied. 3. Perceived access barriers tended to be associated with dissatisfaction.
Evaluation of An Out-patient Pediatric Practice through The Use of Consumer Questionnaires. March, 1975.	To assess the care at a pediatric center, out-patient clinic.	Q/two, self-administered, one given out at visit to be mailed back, a 2nd mailed to patients who had a throat culture taken. Those also mailed back.	Mothers in age range 20 to 30. More than half of the children under 4 years.	Outpatient pediatric service operated by two experienced pediatricians.	- Art of Care - Technical Quality	1. Very high satisfaction rating to nearly all quality questions. An overwhelmingly high level of responses in the "best possible" category.
Consumer Perceptions of Health Care Services: Implications For Academic Medicine. September, 1975.	To study the interrelationships among measures of patients perceptions regarding the characteristics of doctors and health care services.	Q/administered to 903 households. 87 items covering 4 areas: evaluation of health care, beliefs about doctors, reasons for postponing visits, general attitudes towards health care.	Seven county rural areas in Illinois, predominately poor.	General - all medical services.	- Availability - Convenience - Continuity - Finances - Art/Quality of Care	1. Patients more sophisticated in their perceptions of provider behavior than thought. 2. Continuity of care is very important in satisfaction. 3. Satisfaction with Art of Care closely related to patient outcome behavior.

*Q under "Methodology" refers to questionnaire.

TABLE 1-13 (continued)
Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
Physician Conduct and Other Factors That Influence Consumer Satisfaction With Medical Care, October, 1977.	To test the importance of patient perceptions of various characteristics of physicians and medical care services in relation to general satisfaction.	Q/32 page - self administered. Sample of 432. Demographics-socioeconomical factors examined.	General population mid size midwestern city.	General - all medical services.	- Art of Care - Technical Quality - Continuity - Accessibility - Availability	1. Importance of physician conduct consistent across demographic - socioeconomic categories. 2. Physician conduct, ie Art of Care/Quality, was by far the most important factor as it related to general satisfaction.
Expectations and Experience of HMO Enrollees After One Year. An Analysis of Satisfaction, Utilization, and Cost. January, 1978.	To analyze the relationship between pre-enrollment expectations and actual experience of patients in two types of HMO's. "Open Plan" where physicians practice in their own setting and "Closed Plan" with limited number of sites to choose.	Two surveys - 1st taken before sign up. 3 groups, Closed Plan - Open Plan; and Traditional Group Plan (Blue Cross). 2nd Survey taken one year later via telephone and mail out. Sample 449.	Rochester N.Y. Industrial plant offering several health plan options to 3,200 workers.	General - outpatient care in several settings.	- Continuity - Access/Convenience - Finances	1. Were expectations met? Closed - 63% yes Open - 68% yes Blue Cross - 80% yes 2. HMO's attracted families more vulnerable to financial loss. 3. In closed, having a doctor available was big reason for satisfaction.
Factors Associated With Patient Evaluation of Health Care, 1975.	To study the relationships among patient characteristics, the characteristics of the health care encounter, and patient evaluation of that encounter.	Q/given to patient upon entering facility. Form turned in after being self administered. Provider also completed a questionnaire.	General population of Southern California.	Data collected in 11 different medical settings including - clinics, hospitals, offices and HMO's.	- Continuity - Art of Care - Technical Quality	1. 97% generally satisfied feeling that care received was as good as or better than before. 2. Older patients more satisfied. 3. Lower education and minority groups more satisfied than higher educated and whites.

*Q under "Methodology" refers to questionnaire.

TABLE I-13 (continued)

Studies in Patient Attitudes and Characteristics

Study Title	Purpose	*Methodology	Population	Medical Setting	Dimensions	Findings
The Seattle Prepaid Health Care Project Comparisons of Health Services Delivery - Access to Care and Patient Satisfaction. November, 1976	To compare two groups of low income non-Medicaid patient types. Both given health care plan - either group practice plan or Blue Cross fee-for-service.	Surveys taken in 3 intervals - 1 year, 2 years, and 3 years.	Low income, non-Medicaid patients.	General - all services - 1st group enrolled in group practice plan - 2nd group in fee-for-service (Blue Cross).	- Art of Care - Technical Quality - Finances - Access/Convenience	1. In general group enrollees less satisfied. 2. In both plans whites were less satisfied. 3. Perceptions of doctors attitude as negative was greater in group enrollees. 4. A much higher proportion of group enrollees indicated dissatisfaction with treatment received from serious illnesses.
Perceptions of Medical Care. No Date.	To analyze patient satisfaction among poverty groups receiving Medicaid.	Q/administered by interviewers to a random sample of Medicaid recipients in two separate counties.	Medicaid recipients in two Oregon counties.	General - all types of medical services.	- Art of Care - Technical Quality - Access	1. 90% felt care received was as good as general population. 2. 80% very or somewhat satisfied with care. 3. 79% felt medical care could be improved. 4. How to improve? -50% said more doctors -35% said improvement in Art of Care.
A Report of the Pre-Paid Health Research, Evaluation and Development Project: The PHRED Project. (1977 - 1980)	To measure consumer satisfaction among Medicaid clients in California's Pre-Paid Health Plans (PHP's) and HMO's.	Q/random sample of enrollees in 13 different prepaid health plans and from fee-for-service groups in the corresponding geographical areas.	Medicaid recipients in California.	Prepaid Health plans and fee-for-service plans in all medical settings.	- Art of Care - Technical Quality - Access/Convenience - Finances - Physical Environment - Continuity - Efficacy/Outcomes - Availability	1. Prepaid group significantly less satisfied than fee-for-service on all dimensions. 2. Prepays rated most highly were ranked highest in technical quality. 3. The longer a client stays with prepaid the more likely they will remain. 4. Regardless of system, 20% experienced rudeness towards selves or family.

*Q under "Methodology" refers to questionnaire.

APPENDIX D

DETAILED DATA TABLES: UTILIZATION AND COST

TABLE ALL-1
DOCTOR VISITS
ALL RECIPIENTS

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	0.00	1.51	1.51	-0.11
	FFS	812	0.00	1.62	1.62	
MEDIUM USERS	PPSP	2242	5.43	4.81	-0.62	-0.71 *
	FFS	3700	5.59	5.68	0.09	
HIGH USERS	PPSP	366	25.65	16.27	-9.38	-6.77 *
	FFS	700	27.13	24.52	-2.61	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	\$0.00	\$31.89	\$31.89	(\$2.05)
	FFS	812	\$0.00	\$33.94	\$33.94	
MEDIUM USERS	PPSP	2242	\$91.84	\$87.01	(\$4.83)	(\$11.81) *
	FFS	3700	\$97.11	\$104.09	\$6.98	
HIGH USERS	PPSP	366	\$393.01	\$234.12	(\$158.89)	(\$110.92) *
	FFS	700	\$422.14	\$374.17	(\$47.97)	

*Significant at the 5% level.

TABLE ALL-2
PRESCRIPTIONS
ALL RECIPIENTS

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	604	0.00	1.81	1.81	0.15
	FFS	1024	0.00	1.66	1.66	
MEDIUM USERS	PPSP	2028	10.70	10.63	-0.07	-1.18 *
	FFS	3442	10.67	11.78	1.11	
HIGH USERS	PPSP	433	79.86	74.27	-5.59	-9.61 *
	FFS	746	80.18	84.20	4.02	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	604	\$0.00	\$15.31	\$15.31	\$1.10
	FFS	1024	\$0.00	\$14.21	\$14.21	
MEDIUM USERS	PPSP	2028	\$91.60	\$102.95	\$11.35	(\$9.21) *
	FFS	3442	\$92.06	\$112.62	\$20.56	
HIGH USERS	PPSP	433	\$723.30	\$788.26	\$64.96	(\$57.93) *
	FFS	746	\$732.80	\$855.69	\$122.89	

*Significant at the 5% level.

TABLE ALL-3
LABORATORY TESTS
ALL RECIPIENTS

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	891	0.00	3.27	3.27	
	FFS	1514	0.00	3.29	3.29	-0.02
MEDIUM USERS	PPSP	1368	6.39	7.22	0.83	
	FFS	2274	6.45	9.32	2.87	-2.04 *
HIGH USERS	PPSP	806	46.51	27.14	-19.37	
	FFS	1424	49.38	40.44	-8.94	-10.43 *

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	891	\$0.00	\$22.62	\$22.62	
	FFS	1514	\$0.00	\$22.15	\$22.15	\$0.47
MEDIUM USERS	PPSP	1368	\$40.12	\$48.39	\$8.27	
	FFS	2775	\$39.50	\$64.39	\$24.89	(\$16.62) *
HIGH USERS	PPSP	806	\$314.79	\$173.82	(\$140.97)	
	FFS	1424	\$353.97	\$303.44	(\$50.53)	(\$90.44) *

*Significant at the 5% level.

TABLE ALL-4

X-RAYS

ALL RECIPIENTS

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	0.16	0.82	0.66	
	FFS	812	0.15	0.71	0.56	0.10
MEDIUM USERS	PPSP	2242	1.85	1.80	-0.05	
	FFS	3700	1.94	1.92	-0.02	-0.03
HIGH USERS	PPSP	366	7.34	5.14	-2.20	
	FFS	700	7.70	6.77	-0.93	-1.27 *

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	\$2.04	\$11.97	\$9.93	
	FFS	812	\$1.98	\$11.19	\$9.21	\$0.72
MEDIUM USERS	PPSP	2242	\$32.78	\$31.25	(\$1.53)	
	FFS	3700	\$32.55	\$34.00	\$1.45	(\$2.98) (.09)
HIGH USERS	PPSP	366	\$138.55	\$96.56	(\$41.99)	
	FFS	700	\$133.26	\$115.55	(\$17.71)	(\$24.28) *

*Significant at the 5% level.

TABLE ALL-5
EMERGENCY ROOM
ALL RECIPIENTS

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	2516	0.00	0.10	0.10	
	FFS	4068	0.00	0.11	0.11	-0.01
MEDIUM USERS	PPSP	482	1.09	0.28	-0.81	
	FFS	980	1.05	0.37	-0.68	-0.13
HIGH USERS	PPSP	67	3.72	1.06	-2.66	
	FFS	164	3.98	1.56	-2.42	-0.24

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	2516				
	FFS	4068				
MEDIUM USERS	PPSP	482	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	980				
HIGH USERS	PPSP	67				
	FFS	164				

*Significant at the 5% level.

TABLE ALL-6
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

		ALL RECIPIENTS				
		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	0.15	0.53	0.38	
	FFS	812	0.29	0.52	0.23	0.15
MEDIUM USERS	PPSP	2242	1.34	1.10	-0.24	
	FFS	3700	1.46	1.34	-0.12	-0.12
HIGH USERS	PPSP	366	5.98	3.54	-2.44	
	FFS	700	5.71	4.46	-1.25	-1.19

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	\$74.13	\$2514.69	\$2440.56	
	FFS	812	\$93.56	\$324.63	\$231.07	\$2209.49
MEDIUM USERS	PPSP	2242	\$559.18	\$526.39	(\$32.79)	
	FFS	3700	\$669.43	\$689.64	\$20.21	(\$53.00)
HIGH USERS	PPSP	366	\$2229.26	\$1629.36	(\$599.90)	
	FFS	700	\$2281.72	\$2106.29	(\$175.43)	(\$424.47)

*Significant at the 5% level.

TABLE ALL-6(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

ALL RECIPIENTS

		NUMBER OF STAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	0.03	0.08	0.05	
	FFS	812	0.04	0.06	0.02	0.03
MEDIUM USERS	PPSP	2242	0.19	0.17	-0.02	
	FFS	3700	0.23	0.21	-0.02	0.00
HIGH USERS	PPSP	366	0.76	0.46	-0.30	
	FFS	700	0.77	0.62	-0.15	-0.15 (.07)

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	\$74.13	\$251.69	\$177.56	
	FFS	812	\$93.56	\$324.63	\$231.07	(\$53.51)
MEDIUM USERS	PPSP	2242	\$559.18	\$526.39	(\$32.79)	
	FFS	3700	\$669.43	\$689.64	\$20.21	(\$53.00)
HIGH USERS	PPSP	366	\$2229.26	\$1629.36	(\$599.90)	
	FFS	700	\$2281.72	\$2106.29	(\$175.43)	(\$424.47)

*Significant at the 5% level.

TABLE ALL-7
TOTAL AMBULATORY (NON-IPH) SERVICES
ALL RECIPIENTS

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	7.42	13.74	6.32	-0.40
	FFS	812	9.13	15.85	6.72	
MEDIUM USERS	PPSP	2242	40.05	37.17	-2.88	-3.92 *
	FFS	3700	39.59	40.63	1.04	
HIGH USERS	PPSP	366	171.01	125.20	-45.81	-42.39 *
	FFS	700	176.22	172.80	-3.42	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	457	\$88.08	\$198.08	\$110.00	\$69.44
	FFS	812	\$195.21	\$235.77	\$40.56	
MEDIUM USERS	PPSP	2242	\$530.29	\$505.47	(\$24.82)	(\$96.10) *
	FFS	3700	\$489.77	\$561.05	\$71.28	
HIGH USERS	PPSP	366	\$1896.73	\$1541.31	(\$355.42)	(\$333.21) *
	FFS	700	\$2047.37	\$2025.16	(\$22.21)	

*Significant at the 5% level.

TABLE ALL-8
TOTAL TITLE XIX PAYMENTS
ALL RECIPIENTS

		NUMBER OF INVOICE LINES						
		N	Base.	Exper.	Change	Effect		
NON USERS	PPSP	457	7.81	14.84	7.03			
	FFS	812	9.67	17.00	7.33	-0.30		
MEDIUM USERS	PPSP	2242	43.04	39.86	-3.18			
	FFS	3700	43.01	43.93	0.92	-4.10	*	
HIGH USERS	PPSP	366	182.21	132.24	-49.97			
	FFS	700	187.87	182.61	-5.26	-44.71	*	

		COST						
		N	Base.	Exper.	Change	Effect		
NON USERS	PPSP	457	\$162.21	\$449.78	\$287.57			
	FFS	812	\$288.77	\$560.40	\$271.63	\$15.94		
MEDIUM USERS	PPSP	2242	\$1089.43	\$1031.86	(\$57.57)			
	FFS	3700	\$1159.20	\$1250.69	\$91.49	(\$149.06)	(.09)	
HIGH USERS	PPSP	366	\$4125.99	\$3170.67	(\$955.32)			
	FFS	700	\$4329.08	\$4131.45	(\$197.63)	(\$757.69)	*	

*Significant at the 5% level.

TABLE ADC-1
DOCTOR VISITS
ADC RECIPIENTS ONLY

		NUMBER		Change	Effect
		N	Base.		
NON USERS	PPSP	376	0.00	1.47	-0.16
	FFS	657	0.00	1.63	
MEDIUM USERS	PPSP	1782	5.02	4.23	-0.78 *
	FFS	3055	5.30	5.29	
HIGH USERS	PPSP	245	26.27	15.60	-8.30 *
	FFS	500	27.52	25.15	

		COST		Change	Effect
		N	Base.		
NON USERS	PPSP	376	\$0.00	\$33.70	(\$2.81)
	FFS	657	\$0.00	\$36.51	
MEDIUM USERS	PPSP	1782	\$93.55	\$88.70	(\$12.49) *
	FFS	3055	\$101.63	\$109.27	
HIGH USERS	PPSP	245	\$454.22	\$264.61	(\$145.99) *
	FFS	500	\$465.24	\$421.62	

*Significant at the 5% level.

TABLE ADC-2

PRESCRIPTIONS

ADC RECIPIENTS ONLY

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	553	0.00	1.70	1.70	0.18
	FFS	931	0.00	1.52	1.52	
MEDIUM USERS	PPSP	1672	8.82	8.41	-0.41	-1.01 *
	FFS	2944	9.22	9.82	0.60	
HIGH USERS	PPSP	178	80.34	65.74	-14.60	-24.14 *
	FFS	337	83.53	93.07	9.54	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	553	\$0.00	\$13.71	\$13.71	\$1.19
	FFS	931	\$0.00	\$12.52	\$12.52	
MEDIUM USERS	PPSP	1672	\$68.82	\$75.09	\$6.27	(\$6.16) *
	FFS	2944	\$74.14	\$86.57	\$12.43	
HIGH USERS	PPSP	178	\$645.44	\$604.28	(\$41.16)	(\$178.51) *
	FFS	337	\$677.15	\$814.50	\$137.35	

*Significant at the 5% level.

TABLE ADC-3
LABORATORY TESTS
ADC RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	750	0.00	3.33	3.33	
	FFS	1265	0.00	3.34	3.34	-0.01
MEDIUM USERS	PPSP	1101	5.98	6.99	1.01	
	FFS	1879	6.16	9.14	2.98	-1.97 *
HIGH USERS	PPSP	552	47.01	27.19	-19.82	
	FFS	1068	49.60	43.34	-6.26	-13.56 *

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	750	\$0.00	\$23.65	\$23.65	\$1.15
	FFS	1265	\$0.00	\$22.50	\$22.50	
MEDIUM USERS	PPSP	1101	\$38.90	\$47.49	\$8.59	(\$16.59) *
	FFS	2775	\$39.31	\$64.49	\$25.18	
HIGH USERS	PPSP	552	\$353.31	\$189.45	(\$163.86)	(\$117.74) *
	FFS	1068	\$385.78	\$339.66	(\$46.12)	

*Significant at the 5% level.

TABLE ADC-4

X-RAYS

ADC RECIPIENTS ONLY

		NUMBER					
		N	Base.	Exper.	Change	Effect	
NON USERS	PPSP	376	0.15	0.69	0.54	-0.03	
	FFS	657	0.08	0.65	0.57		
MEDIUM USERS	PPSP	1782	1.65	1.45	-0.20	-0.16	(.09)
	FFS	3055	1.74	1.70	-0.04		
HIGH USERS	PPSP	245	7.08	4.90	-2.18	-1.43	*
	FFS	500	7.02	6.27	-0.75		

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	\$1.79	\$12.12	\$10.33	\$0.38
	FFS	657	\$1.27	\$11.22	\$9.95	
MEDIUM USERS	PPSP	1782	\$31.02	\$27.85	(\$3.17)	(\$4.88) *
	FFS	3055	\$31.83	\$33.54	\$1.71	
HIGH USERS	PPSP	245	\$147.95	\$98.07	(\$49.88)	(\$37.05) *
	FFS	500	\$134.47	\$121.64	(\$12.83)	

*Significant at the 5% level.

TABLE ADC-5
EMERGENCY ROOM
ADC RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	1922	0.00	0.11	0.11	
	FFS	3201	0.00	0.11	0.11	0.00
MEDIUM USERS	PPSP	420	1.09	0.28	-0.81	
	FFS	866	1.06	0.37	-0.69	-0.12
HIGH USERS	PPSP	61	3.77	1.05	-2.72	
	FFS	145	3.79	1.32	-2.47	-0.25

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	1922				
	FFS	3201				
MEDIUM USERS	PPSP	420	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	866				
HIGH USERS	PPSP	61				
	FFS	145				

*Significant at the 5% level.

TABLE ADC-6
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

ADC RECIPIENTS ONLY

		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	0.08	0.32	0.24	0.18
	FFS	657	0.11	0.17	0.06	
MEDIUM USERS	PPSP	1782	0.89	0.62	-0.27	-0.14
	FFS	3055	0.96	0.83	-0.13	
HIGH USERS	PPSP	245	4.82	2.94	-1.88	-0.89
	FFS	500	4.48	3.49	-0.99	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	\$70.42	\$207.18	\$136.76	\$24.64
	FFS	657	\$67.38	\$179.50	\$112.12	
MEDIUM USERS	PPSP	1782	\$478.57	\$360.25	(\$118.32)	(\$112.97)(.10)
	FFS	3055	\$550.41	\$545.06	(\$5.35)	
HIGH USERS	PPSP	245	\$2301.98	\$1608.44	(\$693.54)	(\$540.97)
	FFS	500	\$2115.24	\$1962.67	(\$152.57)	

*Significant at the 5% level.

TABLE ADC-6(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)
ADC RECIPIENTS ONLY

		NUMBER OF STAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	0.02	0.06	0.04	
	FFS	657	0.03	0.03	0.00	0.04 *
MEDIUM USERS	PPSP	1782	0.15	0.12	-0.03	
	FFS	3055	0.19	0.16	-0.03	0.00
HIGH USERS	PPSP	245	0.66	0.43	-0.23	
	FFS	500	0.66	0.52	-0.14	-0.09

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	\$70.42	\$207.18	\$136.76	
	FFS	657	\$67.38	\$179.50	\$112.12	\$24.64
MEDIUM USERS	PPSP	1782	\$478.57	\$360.25	(\$118.32)	
	FFS	3055	\$550.41	\$545.06	(\$5.35)	(\$112.97)(.10)
HIGH USERS	PPSP	245	\$2301.98	\$1608.44	(\$693.54)	
	FFS	500	\$2115.24	\$1962.67	(\$152.57)	(\$540.97)

*Significant at the 5% level.

TABLE ADC-7
TOTAL AMBULATORY (NON-IPH) SERVICES
ADC RECIPIENTS ONLY

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	4.26	10.73	6.47	
	FFS	657	4.80	11.64	6.84	-0.37
MEDIUM USERS	PPSP	1782	31.63	27.99	-3.64	
	FFS	3055	32.70	33.77	1.07	-4.71 *
HIGH USERS	PPSP	245	163.54	113.48	-50.06	
	FFS	500	171.68	174.09	2.41	-52.47 *

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	376	\$55.38	\$130.17	\$74.79	
	FFS	657	\$107.93	\$166.06	\$58.13	\$16.66
MEDIUM USERS	PPSP	1782	\$407.42	\$351.16	(\$56.26)	
	FFS	3055	\$413.81	\$457.23	\$43.42	(\$99.68) *
HIGH USERS	PPSP	245	\$1916.20	\$1471.66	(\$444.54)	
	FFS	500	\$2008.40	\$2024.84	\$16.44	(\$460.98) *

*Significant at the 5% level.

TABLE ADC-8
TOTAL TITLE XIX PAYMENTS
ADC RECIPIENTS ONLY

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	376	4.53	11.69	7.16	-0.02
	FFS	657	5.19	12.37	7.18	
MEDIUM USERS	PPSP	1782	34.16	30.03	-4.13	-4.95 *
	FFS	3055	35.71	36.53	0.82	
HIGH USERS	PPSP	245	174.05	120.36	-53.69	-53.62 *
	FFS	500	181.96	181.89	-0.07	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	376	\$125.80	\$337.35	\$211.55	\$41.30
	FFS	657	\$175.31	\$345.56	\$170.25	
MEDIUM USERS	PPSP	1782	\$885.99	\$711.40	(\$174.59)	(\$212.67) *
	FFS	3055	\$964.22	\$1002.30	\$38.08	
HIGH USERS	PPSP	245	\$4218.19	\$3080.10	(\$1138.09)	(\$1001.98) *
	FFS	500	\$4123.63	\$3987.52	(\$136.11)	

*Significant at the 5% level.

TABLE ADC 1-1
DOCTOR VISITS
ADC RECIPIENTS AGE 0-14

		NUMBER			
		N	Base.	Exper.	Change
NON USERS	PPSP	236	0.00	1.41	1.41
	FFS	437	0.00	1.30	1.30
MEDIUM USERS	PPSP	876	4.15	3.34	-0.81
	FFS	1494	4.45	3.58	-0.87
HIGH USERS	PPSP	32	22.56	13.16	-9.40
	FFS	69	22.38	14.62	-7.76

		COST			
		N	Base.	Exper.	Change
NON USERS	PPSP	236	\$0.00	\$29.48	\$29.48
	FFS	437	\$0.00	\$28.78	\$28.78
MEDIUM USERS	PPSP	876	\$77.56	\$65.29	(\$12.27)
	FFS	1494	\$86.03	\$69.56	(\$16.47)
HIGH USERS	PPSP	32	\$418.41	\$223.43	(\$194.98)
	FFS	69	\$354.25	\$261.11	(\$93.14)

*Significant at the 5% level.

TABLE ADC 1-2
 PRESCRIPTIONS
 ADC RECIPIENTS AGE 0-14

		N	NUMBER Base.	Exper.	Change	Effect	
NON USERS	PPSP	391	0.00	1.43	1.43		
	FFS	692	0.00	1.16	1.16	0.27	*
MEDIUM USERS	PPSP	750	4.77	4.18	-0.59		
	FFS	1300	4.97	3.98	-0.99	0.40	(.08)
HIGH USERS	PPSP	3	57.00	39.00	-18.00		
	FFS	8	59.13	45.13	-14.00	-4.00	

		N	COST Base.	Exper.	Change	Effect	
NON USERS	PPSP	391	\$0.00	\$10.30	\$10.30		
	FFS	692	\$0.00	\$8.82	\$8.82	\$1.48	
MEDIUM USERS	PPSP	750	\$31.40	\$31.65	\$0.25		
	FFS	1300	\$34.64	\$30.71	(\$3.93)	\$4.18	*
HIGH USERS	PPSP	3	\$605.07	\$472.91	(\$132.16)		
	FFS	8	\$626.47	\$477.49	(\$148.98)	\$16.82	

*Significant at the 5% level.

TABLE ADC1-3
LABORATORY TESTS
ADC RECIPIENTS AGE 0-14

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	503	0.00	2.03	2.03	0.08
	FFS	892	0.00	1.95	1.95	
MEDIUM USERS	PPSP	612	4.64	4.17	-0.47	0.40
	FFS	1048	4.93	4.06	-0.87	
HIGH USERS	PPSP	29	25.03	9.31	-15.72	-0.11
	FFS	60	28.28	12.67	-15.61	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	503	\$0.00	\$13.22	\$13.22	\$1.07
	FFS	892	\$0.00	\$12.15	\$12.15	
MEDIUM USERS	PPSP	612	\$30.70	\$27.00	(\$3.70)	\$2.71
	FFS	2775	\$31.69	\$25.28	(\$6.41)	
HIGH USERS	PPSP	29	\$173.64	\$63.82	(\$109.82)	\$10.74
	FFS	60	\$209.88	\$89.32	(\$120.56)	

*Significant at the 5% level.

TABLE ADC1-4

X-RAYS
ADC RECIPIENTS AGE 0-14

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	0.07	0.51	0.44	0.04
	FFS	437	0.04	0.44	0.40	
MEDIUM USERS	PPSP	876	0.97	0.90	-0.07	0.20 *
	FFS	1494	1.08	0.81	-0.27	
HIGH USERS	PPSP	32	3.03	2.53	-0.50	0.57
	FFS	69	2.69	1.62	-1.07	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	\$0.00	\$7.67	\$7.67	\$2.21
	FFS	437	\$0.36	\$5.82	\$5.46	
MEDIUM USERS	PPSP	876	\$12.90	\$12.77	(\$0.13)	\$3.08 *
	FFS	1494	\$13.94	\$10.73	(\$3.21)	
HIGH USERS	PPSP	32	\$37.17	\$28.25	(\$8.92)	\$0.17
	FFS	69	\$30.69	\$21.60	(\$9.09)	

*Significant at the 5% level.

TABLE ADC1-5
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

ADC RECIPIENTS AGE 0-14

		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	0.03	0.06	0.03	0.05
	FFS	437	0.05	0.03	-0.02	
MEDIUM USERS	PPSP	876	0.24	0.27	0.03	0.13 *
	FFS	1494	0.35	0.25	-0.10	
HIGH USERS	PPSP	32	2.09	0.31	-1.78	0.28
	FFS	69	3.80	1.74	-2.06	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	\$19.08	\$43.53	\$24.45	\$15.66
	FFS	437	\$18.04	\$26.83	\$8.79	
MEDIUM USERS	PPSP	876	\$102.24	\$148.66	\$46.42	\$98.71 *
	FFS	1494	\$176.39	\$124.10	(\$52.29)	
HIGH USERS	PPSP	32	\$849.79	\$170.62	(\$679.17)	(\$46.00)
	FFS	69	\$1338.14	\$704.97	(\$633.17)	

*Significant at the 5% level.

TABLE ADC1-5(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

ADC RECIPIENTS AGE 0-14

		NUMBER OF STAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	0.01	0.02	0.01	
	FFS	437	0.00	0.01	0.01	0.00
MEDIUM USERS	PPSP	876	0.06	0.06	0.00	
	FFS	1494	0.10	0.06	-0.04	0.04 *
HIGH USERS	PPSP	32	0.53	0.13	-0.40	
	FFS	69	0.70	0.48	-0.22	-0.18

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	\$19.08	\$43.53	\$24.45	
	FFS	437	\$18.04	\$26.83	\$8.79	\$15.66
MEDIUM USERS	PPSP	876	\$102.24	\$148.66	\$46.42	
	FFS	1494	\$176.39	\$124.10	(\$52.29)	\$98.71 *
HIGH USERS	PPSP	32	\$849.79	\$170.62	(\$679.17)	
	FFS	69	\$1338.14	\$704.97	(\$633.17)	(\$46.00)

*Significant at the 5% level.

TABLE ADC1-6

EMERGENCY ROOM

ADC RECIPIENTS AGE 0-14

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	894	0.00	0.12	0.12	0.00
	FFS	1449	0.00	0.12	0.12	
MEDIUM USERS	PPSP	209	1.13	0.31	-0.82	-0.09
	FFS	455	1.11	0.38	-0.73	
HIGH USERS	PPSP	41	4.00	1.10	-2.90	-0.21
	FFS	96	4.09	1.40	-2.69	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	894				
	FFS	1449				
MEDIUM USERS	PPSP	209	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	455				
HIGH USERS	PPSP	41				
	FFS	96				

*Significant at the 5% level.

TABLE ADC1-7
TOTAL AMBULATORY (NON-IPH) SERVICES
ADC RECIPIENTS AGE 0-14

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	3.66	8.78	5.12	0.37
	FFS	437	3.68	8.43	4.75	
MEDIUM USERS	PPSP	876	17.32	15.89	-1.43	1.22 *
	FFS	1494	18.44	15.79	-2.65	
HIGH USERS	PPSP	32	63.31	46.22	-17.09	2.31
	FFS	69	69.54	50.14	-19.40	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	\$38.42	\$99.61	\$61.19	\$7.51
	FFS	437	\$44.53	\$98.21	\$53.68	
MEDIUM USERS	PPSP	876	\$209.31	\$183.39	(\$25.92)	(\$20.32)
	FFS	1494	\$236.72	\$231.12	(\$5.60)	
HIGH USERS	PPSP	32	\$756.26	\$516.87	(\$239.39)	(\$64.86)
	FFS	69	\$751.49	\$576.96	(\$174.53)	

*Significant at the 5% level.

TABLE ADC1-8

TOTAL TITLE XIX PAYMENTS
ADC RECIPIENTS AGE 0-14

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	3.80	9.16	5.36	0.46
	FFS	437	3.79	8.69	4.90	
MEDIUM USERS	PPSP	876	18.20	16.73	-1.47	1.65 *
	FFS	1494	19.76	16.64	-3.12	
HIGH USERS	PPSP	32	69.53	47.91	-21.62	0.54
	FFS	69	77.55	55.39	-22.16	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	236	\$57.50	\$143.14	\$85.64	\$23.17
	FFS	437	\$62.57	\$125.04	\$62.47	
MEDIUM USERS	PPSP	876	\$311.56	\$332.05	\$20.49	\$78.37
	FFS	1494	\$413.11	\$355.23	(\$57.88)	
HIGH USERS	PPSP	32	\$1606.05	\$687.49	(\$918.56)	(\$110.85)
	FFS	69	\$2089.64	\$1281.93	(\$807.71)	

*Significant at the 5% level.

TABLE ADC2-1
DOCTOR VISITS
ADC RECIPIENTS AGE 15-21

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	0.00	1.09	1.09	-1.13 *
	FFS	68	0.00	2.22	2.22	
MEDIUM USERS	PPSP	197	4.61	4.88	0.27	-0.22
	FFS	342	4.85	5.34	0.49	
HIGH USERS	PPSP	17	22.71	14.65	-8.06	-2.69
	FFS	35	21.20	15.83	-5.37	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$0.00	\$26.47	\$26.47	(\$35.46) *
	FFS	68	\$0.00	\$61.93	\$61.93	
MEDIUM USERS	PPSP	197	\$90.12	\$135.86	\$45.74	\$20.40
	FFS	342	\$101.09	\$126.43	\$25.34	
HIGH USERS	PPSP	17	\$556.68	\$306.80	(\$249.88)	(\$99.27)
	FFS	35	\$498.75	\$348.14	(\$150.61)	

*Significant at the 5% level.

TABLE ADC2-2
 PRESCRIPTIONS
 ADC RECIPIENTS AGE 15-21

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	76	0.00	1.63	1.63	-0.45
	FFS	105	0.00	2.08	2.08	
MEDIUM USERS	PPSP	190	9.34	9.37	0.03	0.01
	FFS	331	9.49	9.51	0.02	
HIGH USERS	PPSP	4	66.00	60.75	-5.25	-1.70
	FFS	9	58.11	54.56	-3.55	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	76	\$0.00	\$15.00	\$15.00	(\$5.31)
	FFS	105	\$0.00	\$20.31	\$20.31	
MEDIUM USERS	PPSP	190	\$80.80	\$91.35	\$10.55	\$4.86
	FFS	331	\$80.62	\$86.31	\$5.69	
HIGH USERS	PPSP	4	\$490.41	\$582.29	\$91.88	\$150.18
	FFS	9	\$516.69	\$458.39	(\$58.30)	

*Significant at the 5% level.

TABLE ADC2-3
LABORATORY TESTS
ADC RECIPIENTS AGE 15-21

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	90	0.00	3.58	3.58	-1.10
	FFS	129	0.00	4.68	4.68	
MEDIUM USERS	PPSP	103	6.49	10.84	4.35	-1.49
	FFS	182	7.21	13.05	5.84	
HIGH USERS	PPSP	77	40.45	24.09	-16.36	-5.62 (.10)
	FFS	134	39.46	28.72	-10.74	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	90	\$0.00	\$24.54	\$24.54	(\$6.29)
	FFS	129	\$0.00	\$30.83	\$30.83	
MEDIUM USERS	PPSP	103	\$38.46	\$67.97	\$29.51	(\$15.44)
	FFS	2775	\$42.46	\$87.41	\$44.95	
HIGH USERS	PPSP	77	\$279.04	\$160.45	(\$118.59)	(\$38.94)
	FFS	134	\$279.74	\$200.09	(\$79.65)	

*Significant at the 5% level.

TABLE ADC2-4

X-RAYS

ADC RECIPIENTS AGE 15-21

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	0.00	0.57	0.57	-0.02
	FFS	68	0.09	0.68	0.59	
MEDIUM USERS	PPSP	197	1.80	1.65	-0.15	-0.17
	FFS	342	1.79	1.81	0.02	
HIGH USERS	PPSP	17	4.53	3.41	-1.12	-0.63
	FFS	35	4.80	4.31	-0.49	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$0.00	\$12.90	\$12.90	(\$1.39)
	FFS	68	\$0.61	\$14.90	\$14.29	
MEDIUM USERS	PPSP	197	\$38.89	\$33.75	(\$5.14)	(\$10.59)
	FFS	342	\$37.62	\$43.07	\$5.45	
HIGH USERS	PPSP	17	\$112.12	\$109.60	(\$2.52)	\$7.71
	FFS	35	\$111.02	\$100.79	(\$10.23)	

*Significant at the 5% level.

TABLE ADC2-5
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)
ADC RECIPIENTS AGE 15-21

		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	0.00	0.07	0.07	
	FFS	68	0.06	0.10	0.04	0.03
MEDIUM USERS	PPSP	197	1.01	0.76	-0.25	
	FFS	342	1.23	1.02	-0.21	-0.04
HIGH USERS	PPSP	17	2.94	1.24	-1.70	
	FFS	35	3.40	2.06	-1.34	-0.36

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$0.00	\$78.36	\$78.36	
	FFS	68	\$64.96	\$110.90	\$45.94	\$32.42
MEDIUM USERS	PPSP	197	\$692.26	\$543.68	(\$148.58)	
	FFS	342	\$740.20	\$788.72	\$48.52	(\$197.10)
HIGH USERS	PPSP	17	\$1435.67	\$984.16	(\$451.51)	
	FFS	35	\$1920.43	\$2715.99	\$795.56	(\$1247.07)

*Significant at the 5% level.

TABLE ADC2-5(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

ADC RECIPIENTS AGE 15-21

NUMBER OF STAYS

		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	0.00	0.04	0.04	
	FFS	68	0.03	0.04	0.01	0.03
MEDIUM USERS	PPSP	197	0.25	0.18	-0.07	
	FFS	342	0.26	0.25	-0.01	-0.06
HIGH USERS	PPSP	17	0.47	0.41	-0.06	
	FFS	35	0.74	0.54	-0.20	0.14

COST

		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$0.00	\$78.36	\$78.36	
	FFS	68	\$64.96	\$110.90	\$45.94	\$32.42
MEDIUM USERS	PPSP	197	\$692.26	\$543.68	(\$148.58)	
	FFS	342	\$740.20	\$788.72	\$48.52	(\$197.10)
HIGH USERS	PPSP	17	\$1435.67	\$984.16	(\$451.51)	
	FFS	35	\$1920.43	\$2715.99	\$795.56	(\$1247.07)

*Significant at the 5% level.

TABLE ADC2-6

EMERGENCY ROOM

ADC RECIPIENTS AGE 15-21

NUMBER

		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	222	0.00	0.12	0.12	0.00
	FFS	352	0.00	0.12	0.12	
MEDIUM USERS	PPSP	45	1.04	0.27	-0.77	-0.04
	FFS	85	1.08	0.35	-0.73	
HIGH USERS	PPSP	3	5.33	3.33	-2.00	0.25
	FFS	8	3.75	1.50	-2.25	

COST

		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	222				
	FFS	352				
MEDIUM USERS	PPSP	45	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	85				
HIGH USERS	PPSP	3				
	FFS	8				

*Significant at the 5% level.

TABLE ADC2-7
TOTAL AMBULATORY (NON-IPH) SERVICES
ADC RECIPIENTS AGE 15-21

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	3.54	9.20	5.66	-4.12
	FFS	68	4.43	14.21	9.78	
MEDIUM USERS	PPSP	197	35.48	33.04	-2.44	-3.85
	FFS	342	33.82	35.23	1.41	
HIGH USERS	PPSP	17	118.76	85.06	-33.70	-9.01
	FFS	35	118.43	93.74	-24.69	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$43.66	\$121.35	\$77.69	\$124.86
	FFS	68	\$332.94	\$285.77	(\$47.17)	
MEDIUM USERS	PPSP	197	\$519.67	\$410.03	(\$109.64)	(\$214.10) *
	FFS	342	\$378.30	\$482.76	\$104.46	
HIGH USERS	PPSP	17	\$1416.18	\$1145.67	(\$270.51)	\$23.86
	FFS	35	\$1355.40	\$1061.03	(\$294.37)	

*Significant at the 5% level.

TABLE ADC2-8
TOTAL TITLE XIX PAYMENTS
ADC RECIPIENTS AGE 15-21

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	3.54	9.98	6.44	-4.02
	FFS	68	4.76	15.22	10.46	
MEDIUM USERS	PPSP	197	39.52	36.41	-3.11	-4.71 (.09)
	FFS	342	37.93	39.53	1.60	
HIGH USERS	PPSP	17	127.18	91.82	-35.36	-9.79
	FFS	35	131.03	105.46	-25.57	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	56	\$43.66	\$199.71	\$156.05	\$157.29
	FFS	68	\$397.91	\$396.67	(\$1.24)	
MEDIUM USERS	PPSP	197	\$1211.94	\$953.71	(\$258.23)	(\$411.21) (.09)
	FFS	342	\$1118.50	\$1271.48	\$152.98	
HIGH USERS	PPSP	17	\$2851.85	\$2129.83	(\$722.02)	(\$1223.21)
	FFS	35	\$3275.83	\$3777.02	\$501.19	

*Significant at the 5% level.

TABLE ADC3-1
DOCTOR VISITS
ADC RECIPIENTS AGE 22+

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	0.00	1.88	1.88	-0.44
	FFS	152	0.00	2.32	2.32	
MEDIUM USERS	PPSP	709	6.20	5.14	-1.06	-1.96 *
	FFS	1219	6.47	7.37	0.90	
HIGH USERS	PPSP	196	27.19	16.08	-11.11	-9.95 *
	FFS	396	28.97	27.81	-1.16	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$0.00	\$50.37	\$50.37	\$3.02
	FFS	152	\$0.00	\$47.35	\$47.35	
MEDIUM USERS	PPSP	709	\$114.25	\$104.53	(\$9.72)	(\$41.95) *
	FFS	1219	\$120.90	\$153.13	\$32.23	
HIGH USERS	PPSP	196	\$451.18	\$267.67	(\$183.51)	(\$157.98) *
	FFS	396	\$481.61	\$456.08	(\$25.53)	

*Significant at the 5% level.

TABLE ADC3-2

PRESCRIPTIONS

ADC RECIPIENTS AGE 22+

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	86	0.00	2.99	2.99	0.08
	FFS	134	0.00	2.91	2.91	
MEDIUM USERS	PPSP	732	12.84	12.49	-0.35	-2.67 *
	FFS	1313	13.35	15.67	2.32	
HIGH USERS	PPSP	171	81.09	66.32	-14.77	-25.27 *
	FFS	320	84.85	95.35	10.50	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	86	\$0.00	\$28.10	\$28.10	\$2.57
	FFS	134	\$0.00	\$25.53	\$25.53	
MEDIUM USERS	PPSP	732	\$104.05	\$115.37	\$11.32	(\$19.01) *
	FFS	1313	\$111.61	\$141.94	\$30.33	
HIGH USERS	PPSP	171	\$649.78	\$607.10	(\$42.68)	(\$192.69) *
	FFS	320	\$682.93	\$832.94	\$150.01	

*Significant at the 5% level.

TABLE ADC3-3
LABORATORY TESTS
ADC RECIPIENTS AGE 22+

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	157	0.00	7.36	7.36	-0.33
	FFS	244	0.00	7.69	7.69	
MEDIUM USERS	PPSP	386	7.97	10.44	2.47	-5.92 *
	FFS	649	7.85	16.24	8.39	
HIGH USERS	PPSP	446	49.57	28.89	-20.68	-15.74 *
	FFS	874	52.62	47.68	-4.94	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	157	\$0.00	\$56.57	\$56.57	\$0.62
	FFS	244	\$0.00	\$55.95	\$55.95	
MEDIUM USERS	PPSP	386	\$52.01	\$74.50	\$22.49	(\$48.15) *
	FFS	2775	\$50.74	\$121.38	\$70.64	
HIGH USERS	PPSP	446	\$377.82	\$202.62	(\$175.20)	(\$139.33) *
	FFS	874	\$414.12	\$378.25	(\$35.87)	

*Significant at the 5% level.

TABLE ADC3-4

X-RAYS

ADC RECIPIENTS AGE 22+

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	0.45	1.29	0.84	-0.22
	FFS	152	0.18	1.24	1.06	
MEDIUM USERS	PPSP	709	2.46	2.07	-0.39	-0.61 *
	FFS	1219	2.54	2.76	0.22	
HIGH USERS	PPSP	196	7.96	5.42	-2.54	-1.83 *
	FFS	396	7.97	7.26	-0.71	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$6.45	\$24.12	\$17.67	(\$4.01)
	FFS	152	\$3.43	\$25.11	\$21.68	
MEDIUM USERS	PPSP	709	\$51.24	\$44.85	(\$6.39)	(\$13.08) *
	FFS	1219	\$52.13	\$58.82	\$6.69	
HIGH USERS	PPSP	196	\$169.14	\$108.47	(\$60.67)	(\$46.95) *
	FFS	396	\$154.63	\$140.91	(\$13.72)	

*Significant at the 5% level.

TABLE ADC3-5
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)
ADC RECIPIENTS AGE 22+

		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	0.29	1.25	0.96	
	FFS	152	0.30	0.60	0.30	0.66
MEDIUM USERS	PPSP	709	1.66	1.00	-0.66	
	FFS	1219	1.64	1.49	-0.15	-0.51 (.07)
HIGH USERS	PPSP	196	5.42	3.52	-1.90	
	FFS	396	4.70	3.93	-0.77	-1.13

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$261.61	\$752.85	\$491.24	
	FFS	152	\$210.32	\$649.11	\$438.79	\$52.45
MEDIUM USERS	PPSP	709	\$884.16	\$570.70	(\$313.46)	
	FFS	1219	\$955.56	\$992.63	\$37.07	(\$350.53) *
HIGH USERS	PPSP	196	\$2614.21	\$1897.33	(\$716.88)	
	FFS	396	\$2267.86	\$2115.24	(\$152.62)	(\$564.26)

*Significant at the 5% level.

TABLE ADC3-5(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)
ADC RECIPIENTS AGE 22+

		NUMBER OF STAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	0.07	0.21	0.14	
	FFS	152	0.09	0.09	0.00	0.14 (.06)
MEDIUM USERS	PPSP	709	0.25	0.18	-0.07	
	FFS	1219	0.29	0.27	-0.02	-0.05
HIGH USERS	PPSP	196	0.69	0.48	-0.21	
	FFS	396	0.64	0.53	-0.11	-0.10

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$261.61	\$752.85	\$491.24	
	FFS	152	\$210.32	\$649.11	\$438.79	\$52.45
MEDIUM USERS	PPSP	709	\$884.16	\$570.70	(\$313.46)	
	FFS	1219	\$955.56	\$992.63	\$37.07	(\$350.53) *
HIGH USERS	PPSP	196	\$2614.21	\$1897.33	(\$716.88)	
	FFS	396	\$2267.86	\$2115.24	(\$152.62)	(\$564.26)

*Significant at the 5% level.

TABLE ADC3-6

EMERGENCY ROOM

ADC RECIPIENTS AGE 22+

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	806	0.00	0.10	0.10	-0.02
	FFS	1400	0.00	0.12	0.12	
MEDIUM USERS	PPSP	166	1.04	0.25	-0.79	-0.17
	FFS	326	0.98	0.36	-0.62	
HIGH USERS	PPSP	17	2.94	0.53	-2.41	-0.43
	FFS	44	3.10	1.12	-1.98	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	806	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	1400				
MEDIUM USERS	PPSP	166				
	FFS	326				
HIGH USERS	PPSP	17				
	FFS	44				

*Significant at the 5% level.

TABLE ADC3-7
TOTAL AMBULATORY (NON-IPH) SERVICES
ADC RECIPIENTS AGE 22+

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	6.43	17.24	10.81	-0.71
	FFS	152	8.19	19.71	11.52	
MEDIUM USERS	PPSP	709	48.23	41.53	-6.70	-12.24 *
	FFS	1219	49.86	55.40	5.54	
HIGH USERS	PPSP	196	183.79	126.93	-56.86	-65.47 *
	FFS	396	194.18	202.79	8.61	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$110.83	\$221.92	\$111.09	(\$6.96)
	FFS	152	\$189.53	\$307.58	\$118.05	
MEDIUM USERS	PPSP	709	\$621.00	\$542.09	(\$78.91)	(\$165.27) *
	FFS	1219	\$640.83	\$727.19	\$86.36	
HIGH USERS	PPSP	196	\$2148.95	\$1655.82	(\$493.13)	(\$570.32) *
	FFS	396	\$2285.12	\$2362.31	\$77.19	

*Significant at the 5% level.

TABLE ADC3-8
TOTAL TITLE XIX PAYMENTS
ADC RECIPIENTS AGE 22+

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	7.25	19.96	12.71	0.45
	FFS	152	9.41	21.67	12.26	
MEDIUM USERS	PPSP	709	52.40	44.68	-7.72	-13.17 *
	FFS	1219	54.62	60.07	5.45	
HIGH USERS	PPSP	196	195.18	134.66	-60.52	-67.81 *
	FFS	396	204.66	211.95	7.29	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	84	\$372.43	\$974.76	\$602.33	\$45.50
	FFS	152	\$399.86	\$956.69	\$556.83	
MEDIUM USERS	PPSP	709	\$1505.16	\$1112.79	(\$392.37)	(\$515.80) *
	FFS	1219	\$1596.39	\$1719.82	\$123.43	
HIGH USERS	PPSP	196	\$4763.17	\$3553.15	(\$1210.02)	(\$1134.60) *
	FFS	396	\$4552.97	\$4477.55	(\$75.42)	

*Significant at the 5% level.

TABLE SSI-1
DOCTOR VISITS
SSI RECIPIENTS ONLY

		NUMBER		Change	Effect	
		N	Base. Exper.			
NON USERS	PPSP	81	0.00	1.74	1.74	
	FFS	155	0.00	1.56	1.56	0.18
MEDIUM USERS	PPSP	460	7.06	7.05	-0.01	
	FFS	645	6.95	7.55	0.60	-0.61 (.07)
HIGH USERS	PPSP	121	24.38	17.63	-6.75	
	FFS	200	26.18	22.96	-3.22	-3.53 *

		COST		Change	Effect	
		N	Base. Exper.			
NON USERS	PPSP	81	\$0.00	\$23.48	\$23.48	
	FFS	155	\$0.00	\$23.06	\$23.06	\$0.42
MEDIUM USERS	PPSP	460	\$85.20	\$80.43	(\$4.77)	
	FFS	645	\$75.73	\$79.55	\$3.82	(\$8.59)
HIGH USERS	PPSP	121	\$269.08	\$172.39	(\$96.69)	
	FFS	200	\$314.39	\$255.55	(\$58.84)	(\$37.85)

*Significant at the 5% level.

TABLE SSI-2

PRESCRIPTIONS

SSI RECIPIENTS ONLY

		N	NUMBER Base.	Exper.	Change	Effect
NON USERS	PPSP	51	0.00	3.02	3.02	-0.10
	FFS	93	0.00	3.12	3.12	
MEDIUM USERS	PPSP	356	19.54	21.06	1.52	-2.60 *
	FFS	498	19.24	23.36	4.12	
HIGH USERS	PPSP	255	79.52	80.23	0.71	1.25
	FFS	409	77.43	76.89	-0.54	

		N	COST Base.	Exper.	Change	Effect
NON USERS	PPSP	51	\$0.00	\$32.58	\$32.58	\$1.43
	FFS	93	\$0.00	\$31.15	\$31.15	
MEDIUM USERS	PPSP	356	\$198.58	\$233.81	\$35.23	(\$33.33) *
	FFS	498	\$198.04	\$266.60	\$68.56	
HIGH USERS	PPSP	255	\$777.65	\$916.69	\$139.04	\$28.05
	FFS	409	\$778.64	\$889.63	\$110.99	

*Significant at the 5% level.

TABLE SSI-3
LABORATORY TESTS
SSI RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	141	0.00	2.93	2.93	-0.14
	FFS	249	0.00	3.07	3.07	
MEDIUM USERS	PPSP	267	8.09	8.19	0.10	-2.27 (.06)
	FFS	395	7.81	10.18	2.37	
HIGH USERS	PPSP	254	45.41	27.04	-18.37	-1.41
	FFS	356	48.70	31.74	-16.96	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	141	\$0.00	\$17.12	\$17.12	(\$3.24)
	FFS	249	\$0.00	\$20.36	\$20.36	
MEDIUM USERS	PPSP	267	\$45.18	\$52.09	\$6.91	(\$16.65) (.09)
	FFS	2775	\$40.38	\$63.94	\$23.56	
HIGH USERS	PPSP	254	\$231.06	\$139.85	(\$91.21)	(\$27.47)
	FFS	356	\$258.51	\$194.77	(\$63.74)	

*Significant at the 5% level.

TABLE SSI-4

X-RAYS

SSI RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	0.22	1.43	1.21	0.70
	FFS	155	0.47	0.98	0.51	
MEDIUM USERS	PPSP	460	2.60	3.17	0.57	0.48 (.09)
	FFS	645	2.86	2.95	0.09	
HIGH USERS	PPSP	121	7.86	5.62	-2.24	-0.86
	FFS	200	9.40	8.02	-1.38	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	\$3.21	\$11.25	\$8.04	\$1.95
	FFS	155	\$4.97	\$11.06	\$6.09	
MEDIUM USERS	PPSP	460	\$39.60	\$44.40	\$4.80	\$4.53
	FFS	645	\$35.93	\$36.20	\$0.27	
HIGH USERS	PPSP	121	\$119.53	\$93.49	(\$26.04)	\$3.88
	FFS	200	\$130.23	\$100.31	(\$29.92)	

*Significant at the 5% level.

TABLE SSI-5
EMERGENCY ROOM
SSI RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	594	0.00	0.06	0.06	-0.02
	FFS	867	0.00	0.08	0.08	
MEDIUM USERS	PPSP	62	1.08	0.26	-0.82	-0.22
	FFS	114	0.99	0.39	-0.60	
HIGH USERS	PPSP	6	3.17	1.17	-2.00	0.00
	FFS	19	5.37	3.37	-2.00	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	594	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	867				
MEDIUM USERS	PPSP	62	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	114				
HIGH USERS	PPSP	6	COST FIGURES CURRENTLY NOT AVAILABLE			
	FFS	19				

*Significant at the 5% level.

TABLE SSI-6
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

SSI RECIPIENTS ONLY

		NUMBER OF DAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	0.48	1.46	0.98	0.05
	FFS	155	1.05	1.98	0.93	
MEDIUM USERS	PPSP	460	3.07	2.98	-0.09	-0.03
	FFS	645	3.81	3.75	-0.06	
HIGH USERS	PPSP	121	8.35	4.76	-3.59	-1.66
	FFS	200	8.80	6.87	-1.93	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	\$91.35	\$458.30	\$366.95	(\$368.34)
	FFS	155	\$204.51	\$939.80	\$735.29	
MEDIUM USERS	PPSP	460	\$871.47	\$1169.99	\$298.52	\$157.25
	FFS	645	\$1233.17	\$1374.44	\$141.27	
HIGH USERS	PPSP	121	\$2082.01	\$1671.73	(\$410.28)	(\$177.70)
	FFS	200	\$2697.92	\$2465.34	(\$232.58)	

*Significant at the 5% level.

TABLE SSI-6(B)
TOTAL INPATIENT HOSPITAL
(INCLUDES INSTITUTIONAL AND PROFESSIONAL CHARGES)

SSI RECIPIENTS ONLY

		NUMBER OF STAYS				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	0.07	0.14	0.07	-0.04
	FFS	155	0.10	0.21	0.11	
MEDIUM USERS	PPSP	460	0.33	0.35	0.02	0.01
	FFS	645	0.40	0.41	0.01	
HIGH USERS	PPSP	121	0.96	0.53	-0.43	-0.23
	FFS	200	1.06	0.86	-0.20	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	\$91.35	\$458.30	\$366.95	(\$368.34)
	FFS	155	\$204.51	\$939.80	\$735.29	
MEDIUM USERS	PPSP	460	\$871.47	\$1169.99	\$298.52	\$157.25
	FFS	645	\$1233.17	\$1374.44	\$141.27	
HIGH USERS	PPSP	121	\$2082.01	\$1671.73	(\$410.28)	(\$177.70)
	FFS	200	\$2697.92	\$2465.34	(\$232.58)	

*Significant at the 5% level.

TABLE SSI-7
TOTAL AMBULATORY (NON-IPH) SERVICES
SSI RECIPIENTS ONLY

		Number				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	22.11	27.69	5.58	-0.63
	FFS	155	27.49	33.70	6.21	
MEDIUM USERS	PPSP	460	72.70	72.76	0.06	-0.84
	FFS	645	72.19	73.09	0.90	
HIGH USERS	PPSP	121	186.14	148.92	-37.22	-19.23 *
	FFS	200	187.59	169.60	-17.99	

		Cost				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	\$239.86	\$513.33	\$273.47	\$307.44
	FFS	155	\$565.20	\$531.23	(\$33.97)	
MEDIUM USERS	PPSP	460	\$1006.29	\$1103.28	\$96.99	(\$106.26)
	FFS	645	\$849.51	\$1052.76	\$203.25	
HIGH USERS	PPSP	121	\$1857.31	\$1682.33	(\$174.98)	(\$56.14)
	FFS	200	\$2144.79	\$2025.95	(\$118.84)	

*Significant at the 5% level.

TABLE SSI-8
TOTAL TITLE XIX PAYMENTS
SSI RECIPIENTS ONLY

		NUMBER				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	23.01	29.47	6.46	-1.52
	FFS	155	28.65	36.63	7.98	
MEDIUM USERS	PPSP	460	77.41	77.96	0.55	-0.81
	FFS	645	77.61	78.97	1.36	
HIGH USERS	PPSP	121	198.74	156.29	-42.45	-21.71 *
	FFS	200	202.63	181.89	-20.74	

		COST				
		N	Base.	Exper.	Change	Effect
NON USERS	PPSP	81	\$331.21	\$971.63	\$640.42	(\$60.90)
	FFS	155	\$769.71	\$1471.03	\$701.32	
MEDIUM USERS	PPSP	460	\$1877.75	\$2273.27	\$395.52	\$51.01
	FFS	645	\$2082.68	\$2427.19	\$344.51	
HIGH USERS	PPSP	121	\$3939.32	\$3354.06	(\$585.26)	(\$233.83)
	FFS	200	\$4842.72	\$4491.29	(\$351.43)	

*Significant at the 5% level.

APPENDIX E

CLIENT SATISFACTION SURVEYS

- Exhibit A - Client Satisfaction Survey Letter
(mailing PPSP and FFS Baseline Questionnaires)
- Exhibit B - PPSP and FFS Baseline Questionnaire
- Exhibit C - Client Satisfaction Survey Letter
(mailing PPSP and FFS Experimental Questionnaires)
- Exhibit D - PPSP Experimental Period Questionnaire
- Exhibit E - FFS Experimental Period Questionnaire

- Table 1 - Satisfaction Survey Responses (All Cases)
- Table 2 - Satisfaction Survey Responses (Non Users)
- Table 3 - Satisfaction Survey Responses (Medium Users)
- Table 4 - Satisfaction Survey Responses (High Users)
- Table 5 - Major Satisfaction Dimensions (All Cases)
- Table 6 - Major Satisfaction Dimensions (Non Users)
- Table 7 - Major Satisfaction Dimensions (Medium Users)
- Table 8 - Major Satisfaction Dimensions (High Users)
- Table 9 - Net Change in Satisfaction
- Table 10 - Distribution of Responses by Use Level
- Table 11 - Doctor Visit Arrangements
- Table 12 - Doctor Visit
- Table 13 - Emergencies (All Cases)
- Table 14 - Emergencies (Non Users)
- Table 15 - Emergencies (Medium Users)
- Table 16 - Emergencies (High Users)
- Table 17 - Objective Indicators Comparison to Other Studies
- Table 18 - Travel, Appointment and Waiting Times
- Table 19 - Main Doctor
- Table 20 - Major Satisfaction Dimensions
- Table 21 - Comparison of Satisfaction Dimensions

STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

AGNES M. MANSOUR, Ph.D., Director

June 15, 1983

"THIS IS A SURVEY"

Dear Medicaid Recipient:

We want to know how you feel about the medical care received by you or your family, and also how you feel about people getting help when they are sick or have other medical problems.

Please take a few minutes to fill out this questionnaire and return it in the stamped envelope.

Your feelings about each statement are important. There are no right or wrong answers -- just tell us how you feel.

This is STRICTLY CONFIDENTIAL. Your assistance from Social Services will not be changed by any of your answers -- your Social Services Worker will never see them.

You may have other things you want to tell us about your medical care. If so, please write them at the end of the questionnaire.

Thank you very much for your help.

Sincerely,

Reginald Carter

Reginald Carter, Director
Planning & Evaluation Division

P.S. If there are children in your family, this letter may be addressed to one of them. That has happened because this is a random sample of all people receiving Medicaid. The questionnaire should be completed by an adult but the answers should be about the health care of the person whose name is on this letter.

STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

AGNES M. MANSOUR, Ph.D., Director

March, 1985

"THIS IS A SURVEY"

Dear Medicaid Recipient:

About a year ago, you answered a survey about the medical care you received and your feelings about that care.

Thank you for taking the time to help us with our study of peoples' feelings about medical care.

We are now doing a follow-up survey. We would like to know how you feel about the medical care you have received in the past year.

Please take a few minutes to fill out this survey and return it in the stamped envelope.

Your feelings about each statement are important. There are no right or wrong answers -- just tell us how you feel.

This is STRICTLY CONFIDENTIAL. Your assistance from Social Services will not be changed by any of your answers -- your Social Services Worker will never see them.

Thank you very much for your help.

Sincerely,

Sandra M. Tunteri
Sandra M. Tunteri, Acting Director
Research & Evaluation Division

P.S. If there are children in your family, this letter may be addressed to one of them. That has happened because this is a sample of all people receiving Medicaid. The survey should be completed by an adult but the answers should be about the health care of the person whose name is on this letter.

INSTRUCTIONS: If a statement mentions a doctor, then your answer should be about the doctor you think of as your main doctor.

A. Who do you think of as your main doctor? (Check One Box)

1. ☐ General Practitioner 2. ☐ OB/GYN 3. ☐ Pediatrician 4. ☐ Chiropractor
5. ☐ Other (Explain)

B. Does this doctor mainly take care of an adult or child(ren) in your family?

1. ☐ Adult 2. ☐ Child(ren) 3. ☐ About Half and Half

INSTRUCTIONS: For statement 1 through 21, put a check in the box that shows how you feel about the statement. For example, if the statement is: "My health is good", then check the box which best tells us how you feel about your health. If you're not sure, check the middle box. The way the answer is marked in the example below would tell us that your health is very good.

CHECK ONE BOX FOR EACH STATEMENT

EXAMPLE: My health is good.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
EXAMPLE: My health is good.	✓				
1. I'm very satisfied with the medical care I receive.					
2. In an emergency, it's very hard to get medical care quickly.					
3. Doctors respect their patients' feelings.					
4. Office hours when you can get medical care are good for most people.					
5. Sometimes doctors take unnecessary risks in treating their patients.					
6. The office where I get medical care is clean and comfortable.					
7. Most people receive medical care that could be better.					
8. It takes me a long time to get to the place where I receive medical care.					
9. I have a great deal of confidence in my doctor.					
10. I am in better health now because of the medical care I receive.					
11. It's hard to get an appointment for medical care right away.					
12. The care I have received from doctors in the last few years is just about perfect.					
13. My doctor treats me in a friendly manner					
14. My doctor's office lacks some things needed to provide complete medical care.					
15. I can get medical care whenever I need it.					
16. Doctors are very careful to check everything when examining their patients.					
17. There are things about the medical care I receive that could be better.					
18. Sometimes doctors make the patient feel foolish.					
19. If I have a medical question, I can reach someone for help without any problem.					
20. People are usually kept waiting a long time when they are at the doctor's office.					
21. I would recommend my doctor to a friend needing medical care.					

INSTRUCTIONS: For each question on this page, CHECK THE ONE BOX you feel is closest to your case.

22. When was the last time you got medical care?			
1. <input type="checkbox"/> 0-3 months ago	2. <input type="checkbox"/> 4-6 months ago	3. <input type="checkbox"/> 7-9 months ago	
4. <input type="checkbox"/> 10-12 months ago	5. <input type="checkbox"/> More than 12 months ago		
23. How long does it take you to get to the place where you usually go for medical care?			
1. <input type="checkbox"/> Less than 15 min.	2. <input type="checkbox"/> 15-30 minutes	3. <input type="checkbox"/> 31-60 minutes	4. <input type="checkbox"/> More than 1 hour
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?			
1. <input type="checkbox"/> 2 days or less	2. <input type="checkbox"/> 3 days to 2 weeks	3. <input type="checkbox"/> More than 2 weeks	
25. How long do you usually have to wait to see the <u>doctor</u> , once you get there?			
1. <input type="checkbox"/> 30 minutes or less	2. <input type="checkbox"/> 31-60 minutes	3. <input type="checkbox"/> More than 1 hour	
26. Is there one doctor in particular you usually see at the place you go for medical care?			
1. <input type="checkbox"/> Yes	2. <input type="checkbox"/> No		
27. During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you don't like how you are treated?			
1. <input type="checkbox"/> No, never	2. <input type="checkbox"/> Yes, one time	3. <input type="checkbox"/> Yes, more than once	
28. During the past year, has a doctor or staff person ever been rude to you or to your family?			
1. <input type="checkbox"/> Yes, both doctor and staff	2. <input type="checkbox"/> Yes, only a doctor		
3. <input type="checkbox"/> Yes, only a staff person	4. <input type="checkbox"/> No, never		
29. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?			
1. <input type="checkbox"/> Excellent	2. <input type="checkbox"/> Good	3. <input type="checkbox"/> Fair	4. <input type="checkbox"/> Poor
30. If you need medical care when your doctor's office is not open, which of these do you do?			
1. <input type="checkbox"/> He has given me another number to call.	2. <input type="checkbox"/> I call his answering service & he calls me back.		
3. <input type="checkbox"/> I have to go to the hospital emergency room.	4. <input type="checkbox"/> Other (Explain)		
31. Other Comments			
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			

Please check to be sure you have answered each statement.

THANK YOU.

YOUR FEELINGS ABOUT MEDICAL CARE
Michigan Department of Social Services

Nº 2288

INSTRUCTIONS: If a statement mentions a doctor, then your answer should be about the doctor you think of as your main doctor.

A. Who do you think of as your main doctor? (Check one box)

1. ☐ General Practitioner
5. ☐ Other (Explain)

2. ☐ OB/GYN

3. ☐ Pediatrician

4. ☐ Chiropractor

B. Does this doctor mainly take care of an adult or child(ren) in your family?

1. ☐ Adult

2. ☐ Child(ren)

3. ☐ About Half and Half

INSTRUCTIONS: For statements 1 through 21, put a check in the box that shows how you feel about that statement. For example, if the statement is: "Everyone should have good medical care", then check the box which best tells us how you feel about that statement.

CHECK ONE BOX FOR EACH STATEMENT.

EXAMPLE: Everyone should have good medical care. →

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I'm very satisfied with the medical care I receive.	✓				
2. In an emergency, it's very hard to get medical care quickly.					
3. Doctors respect their patients' feelings.					
4. Office hours when you can get medical care are good for most people.					
5. Sometimes doctors take unnecessary risks in treating their patients.					
6. The office where I get medical care is clean and comfortable.					
7. Most people receive medical care that could be better.					
8. It takes me a long time to get to the place where I receive medical care.					
9. I have a great deal of confidence in my doctor.					
10. I am in better health now because of the medical care I receive.					
11. It's hard to get an appointment for medical care right away.					
12. The care I have received from doctors in the last few years is about perfect.					
13. My doctor treats me in a friendly manner.					
14. My doctor's office lacks some things needed to provide complete medical care.					
15. I can get medical care whenever I need it.					
16. Doctors are very careful to check everything when examining their patients.					
17. There are things about the medical care I receive that could be better.					
18. Sometimes doctors make the patient feel foolish.					
19. If I have a medical question, I can reach someone for help without any problem.					
20. People are usually kept waiting a long time when they are at the doctor's office.					
21. I would recommend my doctor to a friend needing medical care.					

INSTRUCTIONS: For each question, CHECK THE ONE BOX you feel is closest to your case.

22. When was the last time you got medical care?			
1. <input type="checkbox"/> 0-3 months ago	2. <input type="checkbox"/> 4-6 months ago	3. <input type="checkbox"/> 7-9 months ago	
4. <input type="checkbox"/> 10-12 months ago	5. <input type="checkbox"/> More than 12 months ago		
23. How long does it take you to get to the place where you usually go for medical care?			
1. <input type="checkbox"/> Less than 15 minutes	2. <input type="checkbox"/> 15-30 minutes	3. <input type="checkbox"/> 31-60 minutes	4. <input type="checkbox"/> More than 1 hour
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?			
1. <input type="checkbox"/> 2 days or less	2. <input type="checkbox"/> 3 days to 2 weeks	3. <input type="checkbox"/> More than 2 weeks	
25. How long do you usually have to wait to see the doctor, once you get there?			
1. <input type="checkbox"/> 30 minutes or less	2. <input type="checkbox"/> 31-60 minutes	3. <input type="checkbox"/> More than 1 hour	

The Department of Social Services will not discriminate against any individual because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

AUTHORITY: HCFA Grant.
COMPLETION: Voluntary.
PENALTY: None.

26. Is there one doctor in particular you usually see at the place you go for medical care?
1. ☐ Yes 2. ☐ No

27. During the past year have you felt you needed medical care but did not get it?
1. ☐ Yes 2. ☐ No
If yes, answer number 28. If no, go to number 29.

28. Why didn't you get the care you felt you needed? Choose the BEST Answer.
1. ☐ It was too much trouble. 2. ☐ I couldn't get in to see the doctor.
3. ☐ I didn't like the way I was treated. 4. ☐ The problem went away before I saw the doctor.

29. During the past year, has a doctor or staff person ever been rude to you or to your family?
1. ☐ Yes, both doctor and staff. 2. ☐ Yes, only a doctor.
3. ☐ Yes, only a staff person. 4. ☐ No, never.

30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?
1. ☐ Excellent 2. ☐ Good 3. ☐ Fair 4. ☐ Poor

31. If you need medical care when your doctor's office is not open, which of these do you do?
1. ☐ I call the doctor's office and he calls me back. 2. ☐ I call and get no response.
3. ☐ I go to the hospital emergency room. 4. ☐ I wait until the doctor's office opens.
5. ☐ Other

32. Your health is:
1. ☐ Excellent 2. ☐ Good 3. ☐ Fair 4. ☐ Poor

33. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of?
1. ☐ Yes, I was referred. 2. ☐ No, I never needed a referral.
3. ☐ No, I requested one but could not get a referral from my doctor.

34. During the past year, did you go to a different doctor to get a second opinion about a health problem?
1. ☐ Yes 2. ☐ No, I never needed one.
3. ☐ No, I requested it but could not get a referral from my doctor.

35. In comparison to people your age, your health is:
1. ☐ Much better than other people your age. 2. ☐ Better than other people your age.
3. ☐ As good as other people your age. 4. ☐ Worse than other people your age.
5. ☐ Much worse than other people your age.

36. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?
1. ☐ I decided on my own to sign up with my doctor. 2. ☐ My doctor asked me to sign up.
3. ☐ Social Services picked a doctor for me. 4. ☐ Social Services helped me decide.
5. ☐ A relative or friend helped me decide.

37. Are you still signed up with the same doctor?
1. ☐ Yes (Go to 39) 2. ☐ No (Go to 38) 3. ☐ Not Sure (Go to 39)

38. If you are not with the same doctor, why not?
1. ☐ He is no longer in business. 2. ☐ I changed to a doctor with a more convenient location.
3. ☐ I did not like the doctor. 4. ☐ My medical situation changed so I changed doctors.
5. ☐ Other

39. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?
1. ☐ Yes (Go to 41) 2. ☐ No (Go to 40) 3. ☐ Not Sure (Go to 40)

40. What did you think would happen if you didn't sign up quickly?
1. ☐ Nothing. 2. ☐ I would lose my Medicaid benefits. 3. ☐ I would have to go to a new doctor.

41. Are you satisfied with the Medicaid Sponsor Plan?
1. ☐ Yes 2. ☐ No 3. ☐ Not Sure

42. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?
1. ☐ Medicaid Sponsor Plan. 2. ☐ Regular Medicaid card.
3. ☐ Not Sure.

43. Other Comments:

Please check to be sure you have answered each statement.
THANK YOU.

FFS EXPERIMENTAL
QUESTIONNAIRE

Michigan Department of Social Services

INSTRUCTIONS: If a statement mentions a doctor, then your answer should be about the doctor you think of as your main doctor.

A. Who do you think of as your main doctor? (Check One Box)

1. ☐ General Practitioner 2. ☐ OB/GYN 3. ☐ Pediatrician 4. ☐ Chiropractor

5. ☐ Other (Explain)

3. Does this doctor mainly take care of an adult or child(ren) in your family?

1. ☐ Adult 2. ☐ Child(ren) 3. ☐ About Half and Half

INSTRUCTIONS: For statements 1 through 21, put a check in the box that shows how you feel about that statement. For example, if the statement is: "Everyone should have good medical care", then check the box which best tells us how you feel about that statement.

CHECK

CHECK ONE BOX FOR EACH STATEMENT

EXAMPLE: Everyone should have good medical care.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
EXAMPLE: Everyone should have good medical care.	✓				
1. I'm very satisfied with the medical care I receive.					
2. In an emergency, it's very hard to get medical care quickly.					
3. Doctors respect their patients' feelings.					
4. Office hours when you can get medical care are good for most people.					
5. Sometimes doctors take unnecessary risks in treating their patients.					
6. The office where I get medical care is clean and comfortable.					
7. Most people receive medical care that could be better.					
8. It takes me a long time to get to the place where I receive medical care.					
9. I have a great deal of confidence in my doctor.					
10. I am in better health now because of the medical care I receive.					
11. It's hard to get an appointment for medical care right away.					
12. The care I have received from doctors in the last few years is just about perfect.					
13. My doctor treats me in a friendly manner.					
14. My doctor's office lacks some things needed to provide complete medical care.					
15. I can get medical care whenever I need it.					
16. Doctors are very careful to check everything when examining their patients.					
17. There are things about the medical care I receive that could be better.					
18. Sometimes doctors make the patient feel foolish.					
19. If I have a medical question, I can reach someone for help without any problem.					
20. People are usually kept waiting a long time when they are at the doctor's office.					
21. I would recommend my doctor to a friend needing medical care.					

INSTRUCTIONS: For each question on this page, CHECK THE ONE BOX you feel is closest to your case.

22. When was the last time you got medical care?

1. ☐ 0-3 months ago

2. ☐ 4-6 months ago

3. ☐ 7-9 months ago

4. ☐ 10-12 months ago

5. ☐ More than 12 months ago

23. How long does it take you to get to the place where you usually go for medical care?

1. ☐ Less than 15 min.

2. ☐ 15-30 minutes

3. ☐ 31-60 minutes

4. ☐ More than 1 hour

24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?

1. ☐ 2 days or less

2. ☐ 15-30 minutes

3. ☐ More than 2 weeks

25. How long do you usually have to wait to see the doctor, once you get there?

1. ☐ 30 minutes or less

2. ☐ 31-60 minutes

3. ☐ More than 1 hour

26. Is there one doctor in particular you usually see at the place you go for medical care?

1. ☐ Yes

2. ☐ No

27. During the past year have you felt you needed medical care but did not get it?

1. ☐ Yes

2. ☐ No

If yes, answer number 28. If no, go to number 29.

28. Why didn't you get the care you felt you needed? Choose the BEST Answer.

1. ☐ It was too much trouble.

2. ☐ I couldn't get in to see the doctor.

3. ☐ I didn't like the way I was treated.

4. ☐ The problem went away before I saw the doctor.

29. During the past year, has a doctor or staff person ever been rude to you or to your family?

1. ☐ Yes, both doctor and staff

2. ☐ Yes, only a doctor

3. ☐ Yes, only a staff person

4. ☐ No, never

30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?

1. ☐ Excellent

2. ☐ Good

3. ☐ Fair

4. ☐ Poor

31. If you need medical care when your doctor's office is not open, which of these do you do?

1. ☐ He has given me another number to call.

2. ☐ I call his answering service and he calls me back.

3. ☐ I have to go to the hospital emergency room.

4. ☐ This has never happened to me.

5. ☐ Other (Explain)

32. Your health is:

1. ☐ Excellent

2. ☐ Good

3. ☐ Fair

4. ☐ Poor

33. During the past year, did you go to a specialist, that is, another doctor for a health problem that your doctor does not take care of?

1. ☐ Yes

2. ☐ No

34. During the past year, did you go to a different doctor to get a second opinion about a health problem?

1. ☐ Yes

2. ☐ No

35. In comparison to people your age, your health is:

1. ☐ Much better than other people your age.

2. ☐ Better than other people your age.

3. ☐ As good as other people your age.

4. ☐ Worse than other people your age.

5. ☐ Much worse than other people your age.

36. Other comments:

Please check to be sure you have answered each statement.

Thank you.

TABLE 1
SATISFACTION SURVEY RESPONSES

ALL CASES Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
1. I'm very satisfied with the medical care I receive.	4.305	4.299	4.240	4.148
2. In an emergency, it's very hard to get medical care quickly.	3.074	3.049	3.104	3.045
3. Doctors respect their patients' feelings.	4.181	4.145	4.118	4.087
4. Office hours when you can get medical care are good for most people.	4.042	4.011	4.018	3.975
5. Sometimes doctors take unnecessary risks in treating their patients.	3.347	3.297	3.303	3.225
6. The office where I get medical care is clean and comfortable.	4.459	4.426	4.400	4.334
7. Most people receive medical care that could be better.	2.680	2.650	2.656	2.657
8. It takes me a long time to get to the place where I receive medical care.	3.642	3.585	3.641	3.538
9. I have a great deal of confidence in my doctor.	4.250	4.259	4.218	4.086
10. I am in better health now because of the medical care I receive.	3.881	3.862	3.821	3.748
11. It's hard to get an appointment for medical care right away.	3.622	3.548	3.575	3.491

(Table 1 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	ppsp (Exp Grp)	Fee for Service (Cont Grp)	ppsp (Exp Grp)
12. The care I received from doctors in the last few years is just about perfect.	3.818	3.764	3.730	3.700
13. My doctor treats me in a friendly manner.	4.386	4.364	4.326	4.256
14. My doctor's office lacks some things needed to provide complete medical care.	3.542	3.505	3.441	3.386
15. I can get medical care whenever I need it.	3.975	3.957	3.979	3.861
16. Doctors are very careful to check everything when examining their patients.	3.780	3.761	3.765	3.650
17. There are things about the medical care I receive that could be better.	3.031	2.967	2.982	2.980
18. Sometimes doctors make the patient feel foolish.	3.550	3.451	3.482	3.419
19. If I have a medical question, I can reach someone for help without any problem.	3.773	3.714	3.752	3.735
20. People are usually kept waiting a long time when they are at the doctor's office.	2.902	2.796	2.894	2.945
21. I would recommend my doctor to a friend needing medical care.	4.207	4.201	4.134	4.090
22. When was the last time you got medical care?	1.507	1.506	1.679	1.636
23. How long does it take you to get to the place where you usually go for medical care?	1.844	1.837	1.828	1.814

(Table 1 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1.409	1.412	1.564	1.439
25. How long do you usually have to wait to see the doctor, once you get there?	1.609	1.640	1.574	1.605
26. Is there one doctor in particular you usually see at the place you go for medical care?	1.197	1.195	1.218	1.187
27. During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you don't like how you are treated? (BASELINE QUESTIONNAIRE)	1.282	1.302	N/A	N/A
27. During the past year have you felt you needed medical care but did not get it? (PPSP & FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	1.836	1.822
28. Why didn't you get the care you felt you needed? (PPSP AND FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	2.749	2.906
29. During the past year, has a doctor or staff person every been rude to you or to your family? (#28 ON THE BASELINE QUESTIONNAIRE)	3.759	3.736	3.780	3.763
30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)? (#29 ON THE BASELINE QUESTIONNAIRE)	1.813	1.812	1.844	1.846

(Table 1 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
31. If you need medical care when your doctor's office is not open, which of these do you do? (#30 ON THE BASELINE QUESTIONNAIRE)	2.524	2.518	2.939	2.776
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION FOR BOTH THE PPSP AND FFS POST-SURVEY QUESTIONNAIRE:				
32. Your health is:	N/A	N/A	2.319	2.412
33. During the past year, did you go to a specialist that is, another doctor for a health problem that your doctor does not take care of? (FFS POST-SURVEY)	N/A	N/A	1.631	N/A
33. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of? (PPSP POST-SURVEY)	N/A	N/A	N/A	1.616
34. During the past year, did you go to a different doctor to get a second opinion about a health problem?	N/A	N/A	1.778	1.814
35. In comparison to people your age, your health is:	N/A	N/A	2.950	3.000

(Table 1 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION OF THE PPSP POST-SURVEY ONLY:				
36. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?	N/A	N/A	N/A	1.940
37. Are you still signed up with the same doctor?	N/A	N/A	N/A	1.223
38. If you are not with the same doctor, why not?	N/A	N/A	N/A	3.413
39. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?	N/A	N/A	N/A	1.455
40. What did you think would happen if you didn't sign up quickly?	N/A	N/A	N/A	2.129
41. Are you satisfied with the Medicaid Sponsor Plan?	N/A	N/A	N/A	1.571
42. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?	N/A	N/A	N/A	1.881

TABLE 2
SATISFACTION SURVEY RESPONSES

NON-USERS	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
Question:				
1. I'm very satisfied with the medical care I receive.	4.284	4.284	4.205	4.115
2. In an emergency, it's very hard to get medical care quickly.	3.068	2.845	3.236	2.929
3. Doctors respect their patients' feelings.	4.013	3.899	4.145	3.978
4. Office hours when you can get medical care are good for most people.	3.939	3.760	3.973	3.828
5. Sometimes doctors take unnecessary risks in treating their patients.	3.218	3.200	3.158	3.058
6. The office where I get medical care is clean and comfortable.	4.311	4.237	4.399	4.250
7. Most people receive medical care that could be better.	2.378	2.626	2.603	2.430
8. It takes me a long time to get to the place where I receive medical care.	3.500	3.557	3.738	3.448
9. I have a great deal of confidence in my doctor.	4.123	4.093	4.205	3.897
10. I am in better health now because of the medical care I receive.	3.683	3.704	3.870	3.614
11. It's hard to get an appointment for medical care right away.	3.483	3.237	3.583	3.442

(Table 2 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
12. The care I received from doctors in the last few years is just about perfect.	3.728	3.629	3.745	3.614
13. My doctor treats me in a friendly manner.	4.289	4.224	4.324	4.136
14. My doctor's office lacks some things needed to provide complete medical care.	3.438	3.475	3.322	3.310
15. I can get medical care whenever I need it.	3.829	3.837	3.910	3.686
16. Doctors are very careful to check everything when examining their patients.	3.701	3.598	3.819	3.442
17. There are things about the medical care I receive that could be better.	2.834	2.854	2.944	2.851
18. Sometimes doctors make the patient feel foolish.	3.490	3.378	3.469	3.310
19. If I have a medical question, I can reach someone for help without any problem.	3.570	3.558	3.717	3.648
20. People are usually kept waiting a long time when they are at the doctor's office.	2.646	2.485	2.861	2.753
21. I would recommend my doctor to a friend needing medical care.	3.987	3.949	4.130	3.909
22. When was the last time you got medical care?	2.367	2.289	1.979	2.261
23. How long does it take you to get to the place where you usually go for medical care?	1.851	1.907	1.766	1.851

(Table 2 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1.476	1.505	1.500	1.506
25. How long do you usually have to wait to see the doctor, once you get there?	1.628	1.722	1.572	1.713
26. Is there one doctor in particular you usually see at the place you go for medical care?	1.243	1.245	1.246	1.180
27. During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you don't like how you are treated? (BASELINE QUESTIONNAIRE)	1.301	1.327	N/A	N/A
27. During the past year have you felt you needed medical care but did not get it? (PPSP & FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	1.861	1.773
28. Why didn't you get the care you felt you needed? (PPSP AND FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	2.871	2.893
29. During the past year, has a doctor or staff person every been rude to you or to your family? (#28 ON THE BASELINE QUESTIONNAIRE)	3.830	3.808	3.848	3.807
30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)? (#29 ON THE BASELINE QUESTIONNAIRE)	1.906	1.949	1.875	2.022

(Table 2 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
31. If you need medical care when your doctor's office is not open, which of these do you do? (#30 ON THE BASELINE QUESTIONNAIRE)	2.523	2.677	3.028	2.920
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION FOR BOTH THE PPSP AND FFS POST-SURVEY QUESTIONNAIRE:				
32. Your health is:	N/A	N/A	2.222	2.182
33. During the past year, did you go to a specialist that is, another doctor for a health problem that your doctor does not take care of? (FFS POST-SURVEY)	N/A	N/A	1.681	N/A
33. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of? (PPSP POST-SURVEY)	N/A	N/A	N/A	1.690
34. During the past year, did you go to a different doctor to get a second opinion about a health problem?	N/A	N/A	1.792	1.897
35. In comparison to people your age, your health is:	N/A	N/A	2.794	2.847

(Table 2 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION OF THE PPSP POST-SURVEY ONLY:				
36. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?	N/A	N/A	N/A	2.302
37. Are you still signed up with the same doctor?	N/A	N/A	N/A	1.233
38. If you are not with the same doctor, why not?	N/A	N/A	N/A	3.762
39. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?	N/A	N/A	N/A	1.446
40. What did you think would happen if you didn't sign up quickly?	N/A	N/A	N/A	2.152
41. Are you satisfied with the Medicaid Sponsor Plan?	N/A	N/A	N/A	1.511
42. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?	N/A	N/A	N/A	2.000

TABLE 3
SATISFACTION SURVEY RESPONSES

MEDIUM USERS Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
1. I'm very satisfied with the medical care I receive.	4.334	4.300	4.285	4.087
2. In an emergency, it's very hard to get medical care quickly.	3.109	3.047	3.134	3.057
3. Doctors respect their patients' feelings.	4.208	4.163	4.150	4.081
4. Office hours when you can get medical care are good for most people.	4.050	4.026	4.038	3.932
5. Sometimes doctors take unnecessary risks in treating their patients.	3.377	3.330	3.294	3.222
6. The office where I get medical care is clean and comfortable.	4.480	4.455	4.418	4.300
7. Most people receive medical care that could be better.	2.714	2.611	2.672	2.672
8. It takes me a long time to get to the place where I receive medical care.	3.724	3.576	3.722	3.557
9. I have a great deal of confidence in my doctor.	4.268	4.283	4.223	4.023
10. I am in better health now because of the medical care I receive.	3.932	3.856	3.875	3.752
11. It's hard to get an appointment for medical care right away.	3.668	3.564	3.619	3.490

(Table 3 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
12. The care I received from doctors in the last few years is just about perfect.	3.856	3.796	3.776	3.687
13. My doctor treats me in a friendly manner.	4.410	4.367	4.342	4.212
14. My doctor's office lacks some things needed to provide complete medical care.	3.580	3.528	3.420	3.378
15. I can get medical care whenever I need it.	4.025	3.960	4.068	3.917
16. Doctors are very careful to check everything when examining their patients.	3.797	3.783	3.774	3.605
17. There are things about the medical care I receive that could be better.	3.063	2.931	3.008	3.045
18. Sometimes doctors make the patient feel foolish.	3.567	3.477	3.472	3.446
19. If I have a medical question, I can reach someone for help without any problem.	3.794	3.688	3.765	3.709
20. People are usually kept waiting a long time when they are at the doctor's office.	2.968	2.773	2.913	2.892
21. I would recommend my doctor to a friend needing medical care.	4.248	4.225	4.152	4.033
22. When was the last time you got medical care?	1.451	1.478	1.659	1.535
23. How long does it take you to get to the place where you usually go for medical care?	1.798	1.832	1.765	1.816

(Table 3 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1.401	1.380	1.529	1.391
25. How long do you usually have to wait to see the doctor, once you get there?	1.573	1.660	1.560	1.568
26. Is there one doctor in particular you usually see at the place you go for medical care?	1.196	1.193	1.216	1.182
27. During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you don't like how you are treated? (BASELINE QUESTIONNAIRE)	1.247	1.288	N/A	N/A
27. During the past year have you felt you needed medical care but did not get it? (PPSP AND FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	1.866	1.830
28. Why didn't you get the care you felt you needed? (PPSP AND FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	2.836	2.899
29. During the past year, has a doctor or staff person every been rude to you or to your family? (#28 ON THE BASELINE QUESTIONNAIRE)	3.780	3.779	3.779	3.805
30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)? (#29 ON THE BASELINE QUESTIONNAIRE)	1.776	1.806	1.828	1.838

(Table 3 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
31. If you need medical care when your doctor's office is not open, which of these do you do? (#30 ON THE BASELINE QUESTIONNAIRE)	2.540	2.532	2.972	2.792
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION FOR BOTH THE PPSP AND FFS POST-SURVEY QUESTIONNAIRE:				
32. Your health is:	N/A	N/A	2.315	2.426
33. During the past year, did you go to a specialist that is, another doctor for a health problem that your doctor does not take care of? (FFS POST-SURVEY)	N/A	N/A	1.668	N/A
33. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of? (PPSP POST-SURVEY)	N/A	N/A	N/A	1.638
34. During the past year, did you go to a different doctor to get a second opinion about a health problem?	N/A	N/A	1.803	1.846
35. In comparison to people your age, your health is:	N/A	N/A	2.919	3.010

(Table 3 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	P (Exp)
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION OF THE PPSP POST-SURVEY ONLY:				
36. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?	N/A	N/A	N/A	2.
37. Are you still signed up with the same doctor?	N/A	N/A	N/A	1.
38. If you are not with the same doctor, why not?	N/A	N/A	N/A	3.
39. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?	N/A	N/A	N/A	1.
40. What did you think would happen if you didn't sign up quickly?	N/A	N/A	N/A	2.
41. Are you satisfied with the Medicaid Sponsor Plan?	N/A	N/A	N/A	1.
42. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?	N/A	N/A	N/A	1.

TABLE 4
SATISFACTION SURVEY RESPONSES

HIGH USERS Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
1. I'm very satisfied with the medical care I receive.	4.305	4.412	4.215	4.143
2. In an emergency, it's very hard to get medical care quickly.	3.128	2.949	3.130	3.054
3. Doctors respect their patients' feelings.	4.271	4.284	4.132	4.191
4. Office hours when you can get medical care are good for most people.	3.968	4.039	3.987	4.108
5. Sometimes doctors take unnecessary risks in treating their patients.	3.335	3.535	3.483	3.165
6. The office where I get medical care is clean and comfortable.	4.439	4.520	4.364	4.286
7. Most people receive medical care that could be better.	2.797	2.920	2.523	2.689
8. It takes me a long time to get to the place where I receive medical care.	3.430	3.495	3.403	3.438
9. I have a great deal of confidence in my doctor.	4.272	4.461	4.392	4.183
10. I am in better health now because of the medical care I receive.	3.841	4.020	3.809	3.837
11. It's hard to get an appointment for medical care right away.	3.563	3.902	3.622	3.576

(Table 4 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
12. The care I received from doctors in the last few years is just about perfect.	3.766	3.772	3.680	3.725
13. My doctor treats me in a friendly manner.	4.390	4.485	4.371	4.352
14. My doctor's office lacks some things needed to provide complete medical care.	3.447	3.476	3.389	3.344
15. I can get medical care whenever I need it.	4.038	4.029	3.961	3.912
16. Doctors are very careful to check everything when examining their patients.	3.741	4.029	3.831	3.933
17. There are things about the medical care I receive that could be better.	3.045	3.040	3.000	3.056
18. Sometimes doctors make the patient feel foolish.	3.643	3.647	3.540	3.544
19. If I have a medical question, I can reach someone for help without any problem.	3.795	3.786	3.849	3.736
20. People are usually kept waiting a long time when they are at the doctor's office.	2.884	3.098	2.866	3.165
21. I would recommend my doctor to a friend needing medical care.	4.259	4.379	4.301	4.301
22. When was the last time you got medical care?	1.096	1.019	1.168	1.223
23. How long does it take you to get to the place where you usually go for medical care?	1.881	1.981	1.908	1.839

(Table 4 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
24. How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1.244	1.304	1.597	1.371
25. How long do you usually have to wait to see the doctor, once you get there?	1.707	1.437	1.647	1.649
26. Is there one doctor in particular you usually see at the place you go for medical care?	1.133	1.126	1.162	1.141
27. During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you don't like how you are treated? (BASELINE QUESTIONNAIRE)	1.310	1.204	N/A	N/A
27. During the past year have you felt you needed medical care but did not get it? (PPSP & FFS POST-SURVEY QUESTIONNAIRE)	N/A	N/A	1.827	1.835
28. Why didn't you get the care you felt you needed? (PPSP AND FFS POST-SURVEY QUESTIONNAIRE ONLY)	N/A	N/A	2.600	3.130
29. During the past year, has a doctor or staff person every been rude to you or to your family? (#28 ON THE BASELINE QUESTIONNAIRE)	3.747	3.723	3.777	3.681
30. In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)? (#29 ON THE BASELINE QUESTIONNAIRE)	1.777	1.660	1.755	1.685

(Table 4 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
31. If you need medical care when your doctor's office is not open, which of these do you do? (#90 ON THE BASELINE QUESTIONNAIRE)	2.532	2.446	2.775	2.602
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION FOR BOTH THE PPSP AND FFS POST-SURVEY QUESTIONNAIRE:				
32. Your health is:	N/A	N/A	3.007	2.883
33. During the past year, did you go to a specialist that is, another doctor for a health problem that your doctor does not take care of? (FFS POST-SURVEY)	N/A	N/A	1.401	N/A
33. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of? (PPSP POST-SURVEY)	N/A	N/A	N/A	1.456
34. During the past year, did you go to a different doctor to get a second opinion about a health problem?	N/A	N/A	1.632	1.700
35. In comparison to people your age, your health is:	N/A	N/A	3.349	3.389

(Table 4 cont.)

Question:	Pre-Survey		Post-Survey	
	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Seervice (Cont Grp)	PPSP (Exp Grp)
THE FOLLOWING QUESTIONS ARE FOUND AS A CONTINUATION OF THE PPSP POST-SURVEY ONLY:				
36. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?	N/A	N/A	N/A	1.724
37. Are you still signed up with the same doctor?	N/A	N/A	N/A	1.165
38. If you are not with the same doctor, why not?	N/A	N/A	N/A	3.944
39. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?	N/A	N/A	N/A	1.322
40. What did you think would happen if you didn't sign up quickly?	N/A	N/A	N/A	2.255
41. Are you satisfied with the Medicaid Sponsor Plan?	N/A	N/A	N/A	1.489
42. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?	N/A	N/A	N/A	1.750

TABLE 5
MAJOR SATISFACTION DIMENSIONS

	Pre-Survey		Post-Survey		Amount of Change	
	Fee For Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
General Satisfaction with Medical Care	3.466	3.420	3.409	3.372	-.057*	-.048
Accessibility, Convenience	3.582	3.530	3.574	3.524	-.008	-.006
Art of Care	4.041	3.988	3.974	3.917	-.067*	-.071*
Technical Quality of Care	3.813	3.790	3.778	3.666	-.035*	-.124*
Efficacy, Outcomes	3.708	3.687	3.634	3.561	-.074*	.126*
Total of Art and Technical Aspects	3.911	3.876	3.865	3.769	-.046*	-.107*
Physical Environment	3.998	3.968	3.919	3.862	-.079*	-.106*
Availability, Resources	3.699	3.676	3.699	3.627	0.000	-.049
Satisfaction Total	3.748	3.715	3.713	3.638	-.035*	-.077*

*Difference between pre-survey and post-survey is statistically significant at the .05 level.

Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

TABLE 6
MAJOR SATISFACTION DIMENSIONS

Non-Users	Pre-Survey		Post-Survey		Amount of Change	
	Fee For Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
General Satisfaction with Medical Care	3.328	3.354	3.392	3.253	0.091	-0.074
Accessibility, Convenience	3.450	3.361	3.559	3.373	0.119	-0.045
Art of Care	3.932	3.832	3.976	3.774	0.01	-0.056
Technical Quality of Care	3.712	3.644	3.786	3.488	0.073	-0.144
Efficacy, Outcomes	3.557	3.592	3.597	3.465	0.051	-0.082
Total of Art and Technical Aspects	3.818	3.709	3.888	3.601	0.048	-0.097
Physical Environment	3.871	3.856	3.852	3.785	-0.018	-0.082
Availability, Resources	3.615	3.505	3.686	3.490	0.08	0
Satisfaction Total	3.640	3.567	3.697	3.495	0.055	-0.08

*Difference between pre-survey and post-survey is statistically significant at the .05 level.

Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

TABLE 7
MAJOR SATISFACTION DIMENSIONS

Medium Users	Pre-Survey		Post-Survey		Amount of Change	
	Fee For Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)	Fee for Service (Cont Grp)	PPSP (Exp Grp)
General Satisfaction with Medical Care	3.491	3.410	3.450	3.366	-0.039	-0.041
Accessibility, Convenience	3.621	3.519	3.619	3.516	-0.014	-0.007
Art of Care	4.068	4.004	3.982	3.915	-0.089	-0.088
Technical Quality of Care	3.838	3.808	3.792	3.637	-0.076	-0.176
Efficacy, Outcomes	3.755	3.695	3.655	3.558	-0.108	-0.151
Total of Art and Technical Aspects	3.938	3.894	3.875	3.744	-0.089	-0.149
Physical Environment	4.030	3.990	3.919	3.841	-0.11	-0.159
Availability, Resources	3.730	3.677	3.751	3.631	-0.005	-0.043
Satisfaction Total	3.763	3.718	3.747	3.613	-0.05	-0.093

*Difference between pre-survey and post-survey is statistically significant at the .05 level.

Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

TABLE 8
MAJOR SATISFACTION DIMENSIONS

High Users	Pre-Survey		Post-Survey		Amount of Change	
	Fee For Service (Cont Grp)	ppsp (Exp Grp)	Fee for Service (Cont Grp)	ppsp (Exp Grp)	Fee for Service (Cont Grp)	ppsp (Exp Grp)
General Satisfaction with Medical Care	3.490	3.536	3.350	3.377	-0.146	-0.058
Accessibility, Convenience	3.529	3.597	3.554	3.593	0.017	0.07
Art of Care	4.107	4.149	4.023	4.031	-0.054	-0.098
Technical Quality of Care	3.783	4.018	3.884	3.747	0.075	-0.216
Efficacy, Outcomes	3.646	3.762	3.612	3.579	-0.053	-0.121
Total of Art and Technical Aspects	3.924	4.091	3.952	3.882	0.02	-0.183
Physical Environment	3.943	4.005	3.878	3.807	-0.075	-0.195
Availability, Resources	3.706	3.667	3.678	3.697	-0.018	0.082
Satisfaction Total	3.754	3.854	3.700	3.733	0.016	-0.015

*Difference between pre-survey and post-survey is statistically significant at the .05 level.

Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

INSTRUCTIONS:

- Make sure you list the name and ID Number for each person. The Recipient ID Numbers are on your Medicaid card.
- Tear the form off the pamphlet carefully. Tape the form closed with the mailing address on the outside.
- After you fill out the form, sign your name on the bottom line.
- Mail it directly to the Medicaid office. The address is already on the form. The postage is paid by Medicaid.

MEDICAID SPONSOR PLAN ENROLLMENT REQUEST
Michigan Department of Social Services

- ☐ I wish to enroll with my doctor under the Medicaid Sponsor Plan. Please list the doctor for each family member below. Use your Medicaid card for the family member names and Recipient ID Numbers. NOTE: If you go to a clinic, select a doctor from that clinic. DO NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

Client Address

Phone

Sign
here ▶

Client's Signature

- ☐ I do not wish to enroll at this time. Please send me more information on:
☐ Medicaid Sponsor Plan ☐ Health Maintenance Organization (HMO) ☐ Clinic Plan

YOUR MEDICAID CARD - for Each Family Member

- You may choose to continue with me as your sponsor doctor, or you may choose another doctor.
- Other family members may choose me, or they may select another doctor.
- But each family member selects only *one* doctor under the plan.

If you would like me to be your sponsor doctor, please fill out the attached form. If there are other family members you are enrolling with another doctor, list them too.

When I Receive "OUR SPECIAL" Doctor:

- My name and telephone number will be printed on your Medicaid card. It will be about six weeks after you mail the form.
- Also, Medicaid will mail a pamphlet to you, explaining more about the Sponsor plan. The pamphlet is called, **YOU ARE ENROLLED WITH A DOCTOR UNDER THE MEDICAID SPONSOR PLAN.**

To My Family's own Medicaid:

I am a sponsor doctor in the Medicaid Sponsor Plan. If you live in Wayne County and have Medicaid, you can enroll as my patient in the sponsor plan. This pamphlet explains how to enroll. You also have the option to enroll in an HMO or a Clinic Plan.

If You Contact Me as Your Sponsor Doctor:

- I agree to have 24-hour service, seven days a week. If I cannot treat you in my office, you will be told where to get treatment. My name and telephone number will be on your Medicaid card. You call that number when you need medical care.

- If you need medical care from another doctor like a specialist, I will arrange it for you.

- Also, if you enroll in the sponsor plan, you will not have to pay a copayment on pharmacy services.

If you enroll as my patient, you will continue to receive the medical services that you have now. I will help you get all the care you need.

TABLE 9
NET CHANGE IN SATISFACTION

	All Cases	Non Users	Medium Users	High Users
General Satisfaction with Medical Care	.009	-.165	-.002	.088
Accessibility, Convenience	.002	-.164	.007	.053
Art of Care	-.004	-.066	.001	-.044
Technical Quality of Care	-.089*	-.217*	-.100*	-.291*
Efficacy, Outcomes	.200	-.133	-.043	-.068
Total of Art and Technical Aspects	-.061	-.145	-.060	-.203
Physical Environment	-.027	-.064	-.049	-.120
Availability, Resources	-.049	-.080	-.038	-.100
Satisfaction Total	-.042	-.135	-.043	-.031

* Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

TABLE 10 - DISTRIBUTION OF RESPONSES BY USE LEVEL

Question:	All Cases		POST-SURVEY PERIOD				High Users	
	FFS	PPSP	FFS	PPSP	Med. Users	PPSP	FFS	PPSP

A. Your health is:								
1. Excellent	16.0	16.0	21.5	18.2	17.6	15.6	2.6	5.3
2. Good	41.1	38.9	42.4	45.5	43.6	38.2	26.5	26.6
3. Fair	30.6	33.0	28.5	36.4	28.5	34.2	38.4	42.6
4. Poor	12.2	12.1	7.6	0	10.3	12.0	32.5	25.5
B. During the past year, were you referred to a specialist, that is, another doctor for a health problem your doctor does not take care of?								
1. Yes, I was referred.	37.4	41.1	32.6	32.2	33.6	39.1	59.9	60.0
2. No, I never needed one.	62.2	56.2	66.7	66.7	66.1	58.0	40.1	34.4
3. No, I requested it but could not get a referral from my doctor.	N/A	2.7	N/A	1.1	N/A	2.9	N/A	5.6
C. During the past year, did you go to a different doctor to get a second opinion about a health problem?								
1. Yes	22.2	22.4	21.5	14.9	19.7	20.0	36.8	34.4
2. No, I never needed one.	77.7	74.0	77.8	95.4	80.3	75.4	63.2	62.2
3. No, I requested it but could not get a referral from my doctor.	N/A	3.5	N/A	4.6	N/A	4.6	N/A	2.2
D. In comparison to people your age, your health is:								
1. Much better than other people your age.	11.7	10.4	12.8	10.6	11.2	8.6	10.3	6.7
2. Better than other people your age.	8.4	8.2	12.1	5.9	8.7	10.2	4.1	7.8
3. As good as other people your age.	59.8	58.8	61.7	72.9	62.9	59.2	41.1	45.6
4. Worse than other people your age.	13.5	16.2	9.9	9.4	11.1	15.5	29.5	20.0
5. Much worse than other people your age.	6.6	6.4	3.5	1.2	6.0	6.5	15.1	20.0
E. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?								
1. I decided on my own to sign up with a doctor	N/A	64.4	N/A	51.2	N/A	59.9	N/A	71.3
2. My doctor asked me to sign up.	N/A	5.3	N/A	2.3	N/A	5.7	N/A	5.7
3. Social Services picked a doctor for me.	N/A	13.4	N/A	23.3	N/A	18.7	N/A	9.2
4. Social Services helped me decide.	N/A	5.6	N/A	11.6	N/A	4.5	N/A	6.9
5. A relative or friend helped me decide.	N/A	11.3	N/A	11.6	N/A	11.2	N/A	6.9

F. Are you still signed up with the same doctor?

1. Yes	N/A	80.8	N/A	80.2	N/A	81.3	N/A	85.7
2. No	N/A	15.5	N/A	16.3	N/A	15.4	N/A	12.1
3. Not sure	N/A	3.6	N/A	3.5	N/A	3.1	N/A	2.2

G. If you are not with the same doctor, why not?

1. He is no longer in business.	N/A	11.7	N/A	9.5	N/A	8.6	N/A	6.7
2. I changed to a doctor with a more convenient location.	N/A	24.2	N/A	2.3	N/A	5.7	N/A	11.1
3. I did not like the doctor.	N/A	12.1	N/A	0	N/A	14.9	N/A	16.7
4. My medical situation changed so I changed doctors.	N/A	14.8	N/A	28.6	N/A	11.9	N/A	16.7
5. Other	N/A	37.1	N/A	42.9	N/A	32.7	N/A	50.0

H. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a sponsor doctor for you and your family?

1. Yes	N/A	66.8	N/A	66.3	N/A	67.0	N/A	76.7
2. No	N/A	21.1	N/A	22.9	N/A	21.1	N/A	14.4
3. Not sure	N/A	12.1	N/A	10.8	N/A	11.7	N/A	8.9

I. What did you think would happen if you didn't sign up quickly?

1. Nothing	N/A	23.8	N/A	21.7	N/A	22.7	N/A	21.3
2. I would lose my Medicaid benefits.	N/A	39.4	N/A	41.3	N/A	38.8	N/A	31.9
3. I would have to go to a new doctor.	N/A	36.8	N/A	37.0	N/A	38.5	N/A	46.8

J. Are you satisfied with the Medicaid Sponsor Plan?

1. Yes	N/A	60.1	N/A	64.8	N/A	61.3	N/A	64.4
2. No	N/A	22.7	N/A	19.3	N/A	23.3	N/A	22.2
3. Not sure	N/A	17.2	N/A	15.9	N/A	15.5	N/A	13.3

K. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a Medicaid card?

1. Medicaid Sponsor Plan	N/A	29.2	N/A	27.6	N/A	33.0	N/A	35.9
2. Regular Medicaid card	N/A	53.6	N/A	44.8	N/A	52.3	N/A	53.3
3. Not sure	N/A	17.3	N/A	27.6	N/A	14.7	N/A	10.9

The above questions were not applicable to the FFS and PPSP baseline questionnaires.

TABLE 11
Doctor Visit Arrangements

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1. 2 days or less	64.5	59.2	64.3	63.2
	2. 3 days to 2 weeks	30.1	25.2	30.2	29.8
	3. More than 2 weeks	5.4	15.6	5.5	7.1
How long does it take you to get to the place where you usually go for medical care?	1. Less than 15 minutes	36.4	36.2	36.1	37.5
	2. 15-30 minutes	47.4	49.6	47.9	47.4
	3. 31-60 minutes	11.7	9.5	12.3	11.3
	4. More than 60 minutes	4.5	4.7	3.8	3.8
How long do you usually have to wait to see the doctor once you get there?	1. 30 minutes or less	54.5	56.0	51.2	53.8
	2. 31-60 minutes	30.2	30.7	33.6	32.0
	3. More than 1 hour	15.4	13.3	15.2	14.0

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE 12
Doctor Visit

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
When was the last time you got medical care?	1. 0-3 months ago	73.8	67.9	69.7	68.8
	2. 4-6 months ago	14.5	15.2	16.8	15.6
	3. 7-9 months ago	3.8	4.8	5.5	5.2
	4. 10-12 months ago	3.0	5.5	3.4	3.8
	5. More than 12 months ago	4.9	6.6	4.6	6.5
Is there one doctor in particular you usually see at the place you go for medical care?	1. Yes	80.3	78.2	80.5	81.3
	2. No	19.7	21.8	19.5	18.7
During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you didn't like how you are treated?	1. No never,	80.6	83.4	78.9	82.1
	2. Yes, one time	10.7	16.5	12.0	17.8
	3. Yes, more than once	8.7	0.1	9.1	0.1
During the past year, has a doctor or staff person every been rude to you or to your family?	1. Yes, both doctor & staff	3.4	2.6	3.6	2.6
	2. Yes, only a doctor	2.9	3.2	3.3	4.3
	3. Yes, only a staff person	8.2	7.6	9.1	7.5
	4. No, never	85.5	86.5	84.1	85.7
In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?	1. Excellent	36.9	35.4	36.2	36.0
	2. Good	46.7	47.1	47.5	46.3
	3. Fair	14.8	15.4	15.0	14.6
	4. Poor	1.7	2.2	1.3	3.0

TABLE 13
Emergencies

ALL CASES		Percentage of Actual Responses			
QUESTION	RESPONSES	FFS		PPSP	
		Base	Exp	Base	Exp
If you need medical care when your doctor's office is not open, which of these do you do?	1. He has given me another number to call.	15.7	12.7	15.0	N/A
	2. I call his answering service and he calls me back.	22.9	16.4	25.3	N/A
	3. I call the doctor's office and he calls me back.	N/A	N/A	N/A	24.2
	4. I go to the hospital emergency room.	54.7	39.0	52.5	51.6
	5. I call and get no response.	N/A	N/A	N/A	2.1
	6. I wait until the doctor's office opens.	N/A	N/A	N/A	15.9
	7. This has never happened to me.	N/A	27.9	N/A	N/A
	8. Other	6.7	3.9	7.2	6.1

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE 14
Emergencies

NON-USERS		Percentage of Actual Responses			
QUESTION	RESPONSES	FFS		PPSP	
		Base	Exp	Base	Exp
If you need medical care when your doctor's office is not open, which of these do you do?	1. He has given me another number to call.	16.8	14.2	11.5	N/A
	2. I call his answering service and he calls me back.	18.1	12.8	19.8	N/A
	3. I call the doctor's office and he calls me back.	N/A	N/A	N/A	17.2
	4. I go to the hospital emergency room.	61.1	33.3	58.3	62.1
	5. I call and get no response.	N/A	N/A	N/A	0
	6. I wait until the doctor's office opens.	N/A	N/A	N/A	14.9
	7. This has never happened to me.	N/A	35.5	N/A	N/A
	8. Other	4.0	4.3	10.4	5.7

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE 15
Emergencies

MEDIUM USERS		Percentage of Actual Responses			
QUESTION	RESPONSES	FFS		PPSP	
		Base	Exp	Base	Exp
If you need medical care when your doctor's office is not open, which of these do you do?	1. He has given me another number to call.	14.9	11.3	13.8	N/A
	2. I call his answering service and he calls me back.	22.7	16.2	25.0	N/A
	3. I call the doctor's office and he calls me back.	N/A	N/A	N/A	23.5
	4. I go to the hospital emergency room.	55.9	39.4	55.2	51.0
	5. I call and get no response.	N/A	N/A	N/A	17.1
	6. I wait until the doctor's office opens.	N/A	N/A	N/A	14.9
	7. This has never happened to me.	N/A	29.8	N/A	N/A
	8. Other	6.5	3.2	5.9	5.8

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE 16
Emergencies

QUESTION	HIGH USERS RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
If you need medical care when your doctor's office is not open, which of these do you do?	1. He has given me another number to call.	13.3	14.1	15.8	N/A
	2. I call his answering service and he calls me back.	27.2	19.7	27.7	N/A
	3. I call the doctor's office and he calls me back.	N/A	N/A	N/A	26.1
	4. I go to the hospital emergency room.	52.5	44.4	52.5	56.8
	5. I call and get no response.	N/A	N/A	N/A	3.4
	6. I wait until the doctor's office opens.	N/A	N/A	N/A	11.4
	7. This has never happened to me.	N/A	18.3	N/A	N/A
	8. Other	7.0	3.5	4.0	2.3

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE 17
Objective Indicators Comparison to Other Studies

Objective Indicators	CHAS-NORC ^a		FFS		PPSP	
	PHRED ^b		BASE	EXP	BASE	EXP
Travel Time < 15 minutes ^c	48.0%	32.1%	36.2%	36.2%	36.1%	37.5%
Appointment Wait < 2 days	64.0%	51.5%	64.5%	59.2%	64.3%	63.2%
Office Wait < 30 minutes	64.0%	53.3%	54.5%	56.0%	51.2%	53.8%
Have Regular Doctor	78.0%	78.5%	80.3%	78.2%	80.5%	81.3%

^aCenter for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), 1976.

^bPrepaid Health Research, Evaluation, and Development Project (PHRED), California State Department of Health Services, 1979.

^cFor the national sample, this is the percentage traveling less than 15 minutes, so the actual difference is understated in this comparison.

TABLE 18
Travel, Appointment and Waiting Times

	CHAS- NORC ^a	PHRED ^b	FFS		PPSP	
			BASE	EXP	BASE	EXP
Travel Time < 15 minutes ^c	48.0%	32.1%	36.2%	36.2%	36.1%	37.5%
Appointment Wait < 2 days	64.0%	51.5%	64.5%	59.2%	64.3%	63.2%
Office Wait < 30 minutes	64.0%	53.3%	54.5%	56.0%	51.2%	53.8%

^aCenter for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), 1976.

^bPrepaid Health Research, Evaluation, and Development Project (PHRED), California State Department of Health Services, 1979.

^cFor the national sample, this is the percentage traveling less than 15 minutes, so the actual difference is understated in this comparison.

TABLE 19
Main Doctor

Doctor	FFS		PPSP	
	Base	Exp	Base	Exp
General Practitioner	58.3	60.7	58.2	60.2
OB/GYN	14.6	13.1	13.8	12.6
Pediatrician	20.9	17.7	20.8	17.6
Chiropractor	0.8	1.2	0.7	0.6
Other ^A	5.4	7.3	6.5	9.0

Receiving Care^A

Adult	29.4	41.4	26.4	41.2
Child	21.4	18.7	20.5	18.6
Both	43.8	39.9	46.7	40.2
No Answer	5.5		6.4	

^A Most recipients checking this probably meant General Practitioner.

^B A manual review of the forms indicates there may have been some confusion about this question.

The twenty-one statements which actually composed the satisfaction part of the survey were scored on a five point scale ranging from Strongly Disagree (1) to Strongly Agree (5). The mean response to all 21 questions can be found in Table III-16, and interpretation of the mean scores in Table III-15.

TABLE 21
Comparison of Satisfaction Dimensions

Satisfaction Measures	Question Numbers	CHAS-NORC ^a	PHRED ^b	BASE	FFS EXP	BASE	PPSP EXP
General Satisfaction ^c	1,7*,12,17*	3.27	3.35	3.42	3.40	3.39	3.37
Accessibility/Convenience	2*,4,8*,11*,19,20*	3.24	3.43	3.47	3.50	3.45	3.46
Art of Care	3,18*	3.52	3.70	3.84	3.80	3.78	3.75
Technical Quality of Care	5*,16	3.09	3.48	3.53	3.53	3.51	3.44
Physical Environment	14*	3.31	3.56	3.52	3.44	3.54	3.39
Satisfaction Total	All 15	3.27	3.46	3.52	3.51	3.49	3.47

*These were negative statements, so the responses have been reversed to show the positive results.

^aCenter for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), 1976.

^bPrepaid Health Research, Evaluation, and Development Project (PHRED), California State Department of Health Services, 1979.

^cExcept for General Satisfaction, only some items in each of the satisfaction measures were identical in the 1979 and national surveys. Scores were computed by summing item scores for matching items.

APPENDIX F

ADMINISTRATIVE COSTS

Estimates of administrative costs were prepared by the Medical Services Administration (MSA) of the Michigan Department of Social Services.

RECIPIENT ENROLLMENT

1985-86

The following figures indicate the actual enrollment and increase month by month from October 1985 to May 1986.

Month	Recipients Enrolled	Increase Over Previous Month
October 1985	74,330	427
November 1985	77,678	3,348
December 1985	78,149	471
January 1986	78,759	610
February 1986	81,059	2,300
March 1986	81,201	142
April 1986	80,969	(-232)**
May 1986	81,469	500
June 1986	82,569*	
July 1986	83,669*	
August 1986	84,769*	
September 1986	<u>85,869*</u>	
Total Enrollee Months	970,490	
Increase in 7 months	7,798	
Average increase per month	1,100	
$7798 \div 7 = 1114$ (rounded down)		

*Projected enrollment based on actual enrollment for October thru May.

** Excluding decline in April.

Table 20
Major Satisfaction Dimensions

Measure	Question Numbers	Definition of Dimension	Average Scores			
			FFS		PPSP	
			Base	Exp	Base	Exp
General Satisfaction	1,7*,12, 17*,21	Satisfied with medical care received now and during the past few years.	3.42	3.41	3.39	3.37
Accessibility/ Convenience	2*,4,8*, 11*,15,19, 20*	The factors involved in arranging to receive medical care, including distance, ease of travel, waiting time, and the time required to schedule an appointment.	3.54	3.57	3.53	3.52
Art of Care	3,13,18*	The amount of "caring" shown towards patients, an aspect of provider conduct.	4.01	3.97	3.97	3.92
Technical Quality of Care	5*,9,10, 16	The competence of providers and their adherence to high standards of diagnosis and treatment, another aspect of provider conduct.	3.78	3.78	3.76	3.67
Efficacy/ Outcomes	10,21	Perceptions regarding the usefulness or helpfulness of medical care providers.	3.67	3.63	3.68	3.56
Total of Art/ Technical Aspects	3,5*,9, 10,13,16, 18*	A combination of the amount of "caring" shown and the competence of providers.	3.88	3.87	3.85	3.77
Physical Environment	6,14*	The environment of care, including the general pleasantness, comfort and adequacy of the provider's office.	3.98	3.92	3.98	3.86
Availability/ Resources	2*,4,15	The amount of medical care resources in the community.	3.66	3.70	3.65	3.63
Satisfaction Total	All 21		3.71	3.71	3.70	3.64

*These were negative statements, so the responses have been reversed to report the positive results in order to meaningfully combine them with the scores of the positive statements.

ADMINISTRATIVE COSTS

A. Staff Salaries

1985-86

1. Problem Solving Unit (Detroit):

4 Social Worker VIB (29,002.32)	\$ 116,009	
1 Department Analyst VIB (30,693.60) (6 months)	15,347	
1 Social Worker VIIIB	36,519	
1 Secretary IVB	21,611	
Fringe Benefit Package (\$8,900 x 7)	62,300	251,786

1986-87

Staff Salaries 1985-86	\$ 251,786	
1 Departmental Analyst additional six months	15,347	
5% staff salaries increase for 1986-87	13,357	280,490

2. Paper Processing Unit (Lansing):

2 Communications Clerk III (20,504.16)	\$ 41,008	
2 Data Coding Operators III (20,504.16)	41,008	
1 Departmental Manager VIII (.5 FTE) (36,247.68)	18,124	
1 Departmental Manager x (.4 FTE) (44,516.16)	17,806	
Fringe Benefit Package 4.9 (8,900 x 4.9)	<u>43,610</u>	161,556

1986-87

Salaries 1985-86	\$161,556	
5% increase for 1986-87	8,078	169,634

C. Miscellaneous Costs:

a) Rent, postage, printing, equipment, supplies, etc.	\$110,781	
b) Telephones	15,692	
c) Computer Costs	<u>75,000</u>	201,473

Total administrative cost for 1985-86	\$614,815
Total administrative cost for 1986-87	651,597
Total administrative cost for 1987-88	651,597

APPENDIX G

EXHIBITS

1. Notice to Recipient
2. Description of Sponsor Plan
3. CAP Description
4. HMO Flyer
5. PPSP/HMO/CAP Enrollment Form
6. Enrollment Form - Physician's Office Enrollment

NOTICE TO RECIPIENTS IN WAYNE COUNTY
Michigan Department of Social Services

NO PHARMACY COPAYMENT UNDER THE MEDICAID SPONSOR PLAN

Beginning March 1, 1984, you do not need to pay a copayment on drugs if you are enrolled with a Sponsor Doctor.

You can tell if you have a Sponsor Doctor by looking at your Medicaid card. "PHYSICIAN PRIMARY SPONSOR" will be printed on the right-hand side of the card. Your Sponsor Doctor's name and telephone number will also be printed under your name on the card.

"MEDICAL SERVICES ADMINISTRATION" REMOVED FROM THE CARD

Beginning in February, the message "MEDICAL SERVICES ADMINISTRATION." will be removed from Medicaid cards. Sponsor office enrollments were a temporary method which will no longer be used. This means, if you had "MEDICAL SERVICES ADMINISTRATION" on your card, it will be removed. You use the regular card to go to any provider enrolled in the Medicaid program without the Medicaid Sponsor Office approval. Medicaid may contact you in the future to choose a Sponsor Doctor, Health Maintenance Organization (HMO), or a Clinic Plan.

LEARN ABOUT YOUR HEALTH CARE OPTIONS

The Medicaid Sponsor Plan is one way you can get medical care in Wayne County. You may also enroll in an HMO, or Clinic Plan. Currently, HMOs and Clinic Plans in Wayne County do not charge copayments.

If you are interested in receiving information for enrolling with a Sponsor Doctor, an HMO, or a Clinic Plan, please complete the form below and mail it to the address indicated.

NOTE: You may also hear about these health care options through your local worker when your eligibility is being redetermined, your doctor if he or she is a Sponsor Doctor, or through an HMO, or a Clinic Plan.

I would like more information about: (check one or more boxes)

☐ MEDICAID SPONSOR PLAN

☐ HEALTH MAINTENANCE ORGANIZATION

☐ CLINIC PLAN

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____

Mail to: MEDICAID SPONSOR PLAN
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 30037
LANSING, MICHIGAN 48909

Es importante que entienda esta información. Si no la entiende or desea información adicional, llame a su Departamento de Servicios Sociales local.

من المهم جداً أن تفهم هذه المعلومات. إذا كنت لا تفهمها أو كنت تريد المزيد من المعلومات فيجب أن تتصل بالمكتب المحلي لخدمة الخدمات الاجتماعية.

Within the limits of the Medical Assistance program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

Features:

- .You select a sponsor doctor to provide or arrange for most of your medical care.
- .Family members may select the same doctor or different doctors for each person.
- .The name of the doctor you choose will be on your Medicaid card under your name.
- .The doctor's phone number will also be on your Medicaid card. You can call this number any time you need medical care, including after office hours. (Calls after regular office hours should be for conditions which cannot wait until the office reopens.)
- .You may still see specialists. Your sponsor doctor will review your medical needs with you and determine the need for specialty care. You should tell your sponsor doctor about any specialist you are now seeing.
- .You will not have a pharmacy copayment once you are enrolled with a sponsor doctor.
- .You do not need your sponsor's authorization for the following types of care:

..Emergency services	..Chiropractic services
..Hearing and speech services	..Podiatric services
..Most vision services	..Family planning clinic services
..Dental services	..EPSDT (Medicaid screening) for children under age 21
- .The goal of the Medicaid sponsor plan is to assure that you have a doctor who knows you and is aware of your medical needs. Also, to be sure that your doctor is available to help you when you need help.

If you want to enroll with a sponsor doctor, complete the enrollment form included with these materials. Be sure to read the instructions on the enrollment form. A return envelope has also been provided. Once you are enrolled, you will receive a booklet which will tell you a little more about being enrolled with a sponsor doctor including how to change doctors if you wish. Many doctors are part of the Medicaid sponsor plan. If your doctor is not signed up, we will try to have him or her sign a contract with us. In the meantime, you will receive your card as usual.

If you ever have any problems with the Medicaid sponsor plan or want additional information, call 256-9344 or write:

Medicaid Sponsor Plan
921 West Holmes
Lansing, Michigan 48910

Es importante que entienda esta información. Si no la entiende or desea información adicional, llame a su Departamento de Servicios Sociales local.

من المهم جداً أن تفهم هذه المعلومات. إذا كنت لا تفهمها أو كنت تريد المزيد من المعلومات فيجب أن تتصل بالمكتب المحلي لدائرة الخدمات الاجتماعية.

Within the limits of the Medical Assistance program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

CLINIC PLAN INFORMATION
Michigan Department of Social Services

Thank you for asking about the Medicaid Clinic Plan. The following information may be helpful to you in deciding whether to enroll with this program:

- .Care will be available to you and your family on a 24 hour-a-day basis, seven days a week. Through the clinic, you will be provided with complete health care. And most care will be provided at one location.
- .No Medicaid copayments are charged - you do not pay part of the cost of medical services you receive.
- .When ordered by a doctor, over-the-counter drugs are available, without charge to you, at all the clinics listed below.
- .All eligible family members will be enrolled in the same clinic plan at the same time. The family members may choose to have the same doctor in the clinic. Or each family member may choose a different doctor within the clinic.
- .You will get all covered health care at the clinic you select, unless the clinic sends you to another provider for care which the clinic cannot provide. (This is known as a referral.)
- .Nonemergency hospitalization, if needed, will be arranged for you at a hospital.
- .If you have an emergency which is a threat to your life, you should go to the nearest hospital. If the emergency is not life threatening, the clinic has made arrangements to, or will, meet your medical needs at any time of the day or night. Ask the clinic for details.
- .Dental care will not be provided at the clinic. You will continue to receive dental care as you do now.
- .Once enrolled, you must remain in the clinic plan for at least one month. (Medicaid requires a monthly enrollment in any of its health options. If you decide you no longer wish to remain with a certain health option, your health care will not be interrupted.)
- .You will be issued your Medicaid ID card with the message "CLINIC PLAN ENROLLEE" printed on the card. The card will show the clinic plan name and telephone number. You may call the telephone number on the card at any time.

The clinic plan is available at the following five locations in Wayne County. Please contact the clinic if you would like more information:

Blain Clinic
2141 Jefferson Avenue East
Detroit, Michigan 48207
568-2025 or 836-1055

Comprehensive Medical Clinic
3338 West Davison
Detroit, Michigan 48203
865-7600 or 836-1055

McSwain-Orr Clinic
6872 West Warren
Detroit, Michigan 48210
898-8077 or 836-1055

S & S Medical Clinic
18211 Schoolcraft
Detroit, Michigan 48223
493-4330 or 836-1055

Midwest Health Center
5050 Schaefer Road
(1/2 Block North of
Michigan Avenue
Dearborn, MI. 48126
581-2600

Please Note: A 24-hour outpatient care unit is available to meet your needs at Midwest Health Center (listed above).

If you want to enroll with the clinic plan, complete the enrollment form included with these materials. Be sure to read the instructions on the enrollment form and please be sure to give the name of your doctor. A return envelope has also been provided. Once you are enrolled, you will receive a letter which will tell you a little more about being enrolled with the clinic plan.

If you ever have any problems with the clinic plan or want additional information, call 256-9344 or write:

Clinic Plan
921 West Holmes
Lansing, Michigan 48910

Es importante que entienda esta información. Si no la entiende o desea información adicional, llame a su Departamento de Servicios Sociales local.

من أنتم جداً أن تفهم هذه المعلومات. إذا كنت لا تفهمها أو كنت تريد المزيد من المعلومات فيجب أن تتصل بالكتب المحلي لخدمة الخدمات الاجتماعية.

Within the limits of the Medical Assistance program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

**YOUR
PERSONAL GUIDE
TO**

**HEALTH
MAINTENANCE
ORGANIZATIONS**

What You Should Know About HMOs

For Medicaid Card Holders

STATE OF MICHIGAN



WILLIAM G. MILLIKEN, Governor

DEPARTMENT OF SOCIAL SERVICES

300 S. CAPITOL AVENUE, LANSING, MICHIGAN 48926

SPECIAL ANNOUNCEMENT TO MEDICAID CARD HOLDERS:

The Department of Social Services announces an option in health care for you and your family.

You can join one of the six Health Maintenance Organizations (HMOs) shown in this booklet.

These plans will provide all the medical services you now receive under Medicaid. The services of the HMOs are designed not only to treat your illnesses, but also to help keep you and your family well.

The HMOs will provide care at one location nearest your home. Hospital care and other special care will be arranged for you by your HMO.

The HMOs have staff available to help 24 hours per day, 7 days a week. You will be given a phone number you may call anytime in an emergency.

To get more information, contact one or more of the HMOs shown in this booklet.

THINGS TO CONSIDER

The Following Features are Highlights of the HMO Option

- **Eyeglasses and Exams**

Through the HMO comprehensive eye care centers you receive eye exams as needed. Eyeglasses are provided when medically necessary.

- **Prescription Co-Pay**

Through the HMOs there are no co-pays on authorized or covered prescription drugs.

- **Semi Private Hospital Rooms**

HMOs offer semi-private room accommodations for all authorized hospital admissions.

- **Emphasize Prevention**

HMOs stress prevention by providing routine physical examinations, nutrition services and family counseling.

- **Home Health Care**

When authorized by your HMO physician, health professionals are available to care for you in your home.

- **Centralized Medical Records**

When you select an HMO, your medical records will be kept at one central, convenient location at the health center you select.

- **Consumer Satisfaction System**

HMOs have an established, formal system for resolving any service problems or member concerns.

- **Routine Physical Exams**

HMOs encourage routine physical exams, whether you have a medical problem or do not.

- **Hearing Services**

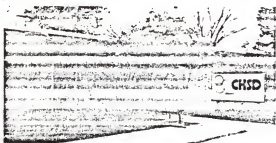
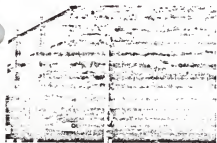
Hearing services are covered when you are a member of an HMO.

**MEDICAID CARD HOLDERS
now have to make an important decision:
WHICH HMO FITS YOUR NEEDS?**

The following pages provide information on each of the HMO choices available.

CHSD has three Health Centers in the City of Detroit, and you can select the one most convenient to you:

WE CARE



1 Plaza Health Center
6500 John C. Lodge

2 Schaefer Health Center
18400 Schaefer

3 East Side Facility
4909 E. Outer Drive



We contract with the following hospitals to provide care for our members:

Affiliated Hospitals

- A—Grace Hospital, Northwest
18700 Meyers
- B—Harper-Grace Hospital
3990 John R. Street
- C—Hutzel Hospital
4707 St. Antoine
- D—Rehabilitation Institute
261 Mack
- E—Children's Hospital of Michigan
3901 Beaubien
- F—Southwest Detroit General
2401 20th Street
- G—Good Samaritan Hospital, East
(St. Joseph's Mercy Hospital)
2200 East Grand Boulevard

Plaza: Monday through Friday
8:30 A.M.-5:00 P.M.

Urgent Care: 5:00 P.M.-11:00 P.M.
(Plaza Center)

Plaza Pharmacy Hours: Monday through Friday
9:00 A.M.-11:00 P.M.
Saturday
9:00 A.M.-5:00 P.M.

Schaefer: Monday through Friday
8:30 A.M.-5:00 P.M.

East Side: Monday through Friday
8:30 A.M.-5:00 P.M.

East Side Pharmacy Hours: Monday through Friday
9:00 A.M.-5:00 P.M.

Emergency: During the day, call your Health Center.

After office hours,
call 875-4200

At the Health Center
Visits to Doctor
Referrals to outside Specialists
Consultation and Treatment by Specialists

Health Examinations
Allergy Tests and Treatment
Pre-Natal and Post-Natal Care (Maternity and Baby Care)

Well-Baby Care
Ear & Eye Examinations
Eyeglasses

Family Planning Services (counseling, supplies, and Medical procedures)
Health Education Services
Laboratory Tests
X-rays

Injectons and Immunizations
Pharmacological Counseling (how to take and use prescribed drugs)
Prescription Drugs Obtained at Health Center Pharmacy

Nutrition, Special Diet, and Home Economist Services
Mental Health and Social Work Services
Alcohol & Drug Abuse Treatment Services

Prosthetic appliances when prescribed by a CHSD physician (including artificial arms and legs, prescription shoes, wheelchairs, crutches, etc.)
Complete Podiatric Services (care of the feet)

Emergency ambulance service when necessary



COMPREHENSIVE HEALTH SERVICES OF DETROIT, INC.
(A Michigan Nonprofit Corporation and Federally Qualified HMO)

Now is the time to join Group Health Plan

With GHP you get:

- Extensive benefits
- Virtual elimination of out-of-pocket costs including deductibles and co-payments
- Medical care when you need it
- Two modern convenient locations for out-patient medical services
- Personalized quality health care
- Emphasis on prevention, early diagnosis and prompt treatment of medical problems
- Affiliation with quality hospitals
- No itemized receipts to maintain or claim forms to submit



Troy Health Center



Sunset Plaza—Livernois and Long Lake Rds. • Troy, Michigan 48098

Warren Health Center



21000 Mound Rd.—North of Eight Mile Rd. • Warren, Michigan 48091

GHP HEALTH CENTERS

- | | |
|---|--|
| 1 Troy Health Center
Sunset Plaza
(Livernois & Long Lake Roads)
Troy, Michigan 48098 | 2 Warren Health Center
21000 Mound Road
(North of Eight Mile Road)
Warren, Michigan 48091 |
|---|--|

AFFILIATED HOSPITALS

- | | |
|---|---|
| 3 Wm. Beaumont, Troy —
44201 Dequindre, Troy | 6 Hutzel — 4707 St. Antoine, Detroit |
| 4 Wm. Beaumont, Royal Oak
3601 West 13 Mile, Royal Oak | 7 Harper — 3950 John R., Detroit |
| 5 So. Macomb — 11800 12 Mile, Warren | 8 Children's Hospital of Michigan
3901 Beaubien, Detroit |

For further information call 879-5600



**GROUP HEALTH PLAN
of Southeast Michigan**

Michigan's First Federally Qualified HMO
A Non-Profit Corporation

Administrative Offices: Two Northfield Plaza, Suite 115 • 5700 Crooks Road • Troy, Michigan 48098 • PHONE: 879-5600



**HAP leads
the way to
good health
for more
Michigan
families
than any
other HMO**

CHOOSE Health Alliance Plan (HAP)! Use our ID card instead of the Medicaid card and get these extra benefits:

- **PERSONAL CARE:** Our system of health care includes your personal HAP doctor and patient representatives in all our Health Centers who help you understand your family's medical needs, assist you in health education and answer questions about Medicaid coverage.
With HAP, you'll never have to go to your caseworker to solve personal health care problems.
- **ID CARDS:** You and each member of your family receive the HAP plastic ID card that gives you the same quality care and personal attention that over 44,000 Ford, Chrysler and General Motors members receive. Many school and university teachers: city, state and federal employees, and employees of banks, credit unions and other industries have chosen HAP over any other health care plan in the state.
- **ONE-STOP HEALTH CENTER:** You do not have to waste your time nor worry about transportation to get to one place to see your personal HAP doctor, your children's pediatrician, and specialist . . . and another place to have x-rays taken . . . and another for tests. That's because most routine health care services are done right at HAP's one-stop Health Centers.
- **EMERGENCY CARE:** You have peace of mind because you are always covered in an emergency, 24 hours a day at Metropolitan Hospital, Metropolitan West Hospital, Henry Ford Hospital, Fairlane, Sterling Heights and West Bloomfield Health Centers — *without having to call first and wait for an approval.* Emergency care is also covered at the nearest hospital if you can't get to one of the HAP facilities. That includes when traveling outside of the tri-county area. Your ID card has an emergency hot-line phone number on the back if you should have any questions.



Health Alliance Plan

2850 W. Grand Blvd., Detroit, MI 48202

a non-profit corporation
in association with

Henry Ford Hospital
and METROPOLITAN HOSPITAL

FIND OUT MORE . . . CALL

876-3444

Leading the way to your good health



JOIN INDEPENDENCE HEALTH PLAN A PERSONAL HEALTH CARE PLAN

A NEW WAY TO SERVE YOUR HEALTH CARE NEEDS:

- Your own Family Doctor backed by a team of specialists
- Personal appointments for office visits
- 24 hour doctor on call - 365 days a year
- A wide range of medical specialties and diagnostic facilities at your Medical Center
- Prescriptions available at the Medical Center or any Perry, or Arbor, Drug Store
- Complete emergency coverage anywhere
- Well known hospital affiliations
- More comprehensive benefits - an emphasis on Prevention
- An Independence ID Card for each member of the family
- A Medical Center Coordinator at each Center to answer questions or solve problems

PRIMARY PRACTICE HOSPITALS

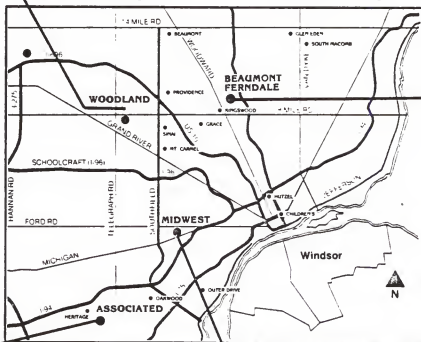
William Beaumont Hospital
Children's Hospital
Harper-Grace Hospital
Mt. Carmel Mercy Hospital
Providence Hospital
Sinai Hospital
South Macomb Hospital
Heritage Hospital
Oakwood Hospital
Outer Drive Hospital
Botsford
Garden City Osteopathic Hospital
Kern Hospital
Plymouth General Hospital
Pontiac General Hospital
Riverside Hospital
St. Mary Hospital
Southwest Detroit Hospital



Woodland Medical Center
22341 Eight Mile
(near Lahser)
Detroit, Michigan



William Beaumont - Ferndale
911 East Nine Mile Road
(east of Hilton)
Ferndale, Michigan



Associated Physicians
24555 Haig (near Telegraph)
Taylor, Michigan



Midwest Health Center, P.C.
5050 Schaefer Road
(near Michigan Ave.)
Dearborn, Michigan

Medicaid eligibles are now offered the opportunity to join Independence Health Plan for their medicaid benefits. If they elect coverage, their Medicaid Card will be replaced by an Independence Health Plan ID Card, and all of their medical services will be provided through one of Independence's comprehensive Medical Centers in Southeastern Michigan.

The emphasis at Independence is on **personalized, comprehensive, and well coordinated** health care. Independence members have their own family doctor and they make appointments to see the doctor and avoid long waiting times. A wide range of specialists and services are available at the center for one-stop medical care. And at Independence the emphasis is on prevention to get members healthy and keep them that way.

For additional information call Independence Health Plan at 552-9396.

Michigan HMO Plans offers more locations for primary health care services!

Michigan HMO Plans is a prepaid health care program that represents an alternative to traditional types of medical and hospitalization care. Michigan HMO Plans offers benefits that most plans do not.

Emphasis is placed on preventive health care, hopefully to detect and treat minor illnesses in an effort to avoid more serious ones.

Emergency care in the service area can be received at most area hospitals. Emergency care outside of the service area should be accessed at the closest hospital or emergency room.

Michigan HMO Plans Coverage Provides:

- More than 40 Health Care Centers
- Over 40 affiliated Hospitals
- 500 Participating Physicians
- Over 300 Participating Pharmacies
- Unlimited Hospitalization
- All Prescription Drugs
- 24-Hour...7 Days a Week Emergency "Hotline"



For further information or
to arrange to visit one
of our facilities, phone:

961-1610 — Ext. 231

HAPPINESS LOVES COMPANY



HERE'S WHY TOTAL HEALTH CARE MEMBERS ARE HAPPY

- No Out-of-Pocket Cost
- Doctor Office Visits Paid in Full
- Routine Hearing Exams Paid in Full
- Prescription Medication Paid in Full
- No Deductibles or Co-Payments
- Ophthalmology Care Paid in Full
- Routine Optometry and Complete Surgical Care Paid in Full

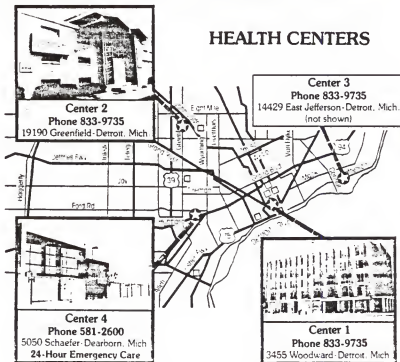
Coverage for virtually all health care needs.

Benefits are covered in full—you need only think about getting well . . . not the cost of getting well.

If you have a medical condition for which you need advice or treatment, you may contact the Plan 24 hours a day, 7 days a week.

Plan Members receive most of their care at one of our conveniently located Health Centers. Specialty care is available and coordinated through your Plan Physician. Coordination of medical care is stressed for all Plan Members.

HEALTH CENTERS



ASSOCIATED HOSPITALS

- Hutzel Hospital
- Grace N.W. Hospital
- Harper Grace
- Plymouth General Hospital
- St. Joseph Mercy Hospital
- Childrens Hospital
- Mount Carmel Mercy Hospital
- Southwest Detroit Hospital



A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION—3455 WOODWARD, DETROIT, MICHIGAN 48201
A Non Profit Corporation

FOR FURTHER INFORMATION CALL 833-9735 Ext. 229

8

**Remember
You Must Call**

256-9344

**to choose your HMO
within 7 days**

***If you do not call with your choice, the
Medicaid Specialist will assign you to
one of the six HMO's in this booklet.***

4

**FOR MEDICAID
CARD HOLDERS**

YOUR PERSONAL GUIDE TO

**HEALTH
MAINTENANCE
ORGANIZATIONS**

What You Should Know About HMOs

Place
Postage
Here

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY
Michigan Department of Social Services

Medicaid is offering three options in medical care for you and your family:

- a doctor under the Medicaid Sponsor Plan,
- a Health Maintenance Organization (HMO), or
- a Clinic Plan. Most clinics are NOT Clinic Plans. If your doctor is in a clinic, call the clinic to see if it is a Clinic Plan.

You choose which option you want to enroll in and complete the attached form. If you need more information on the three options, call 256-9344. You must return the completed form to your caseworker.

The options are designed for you to go to one Sponsor Doctor, an HMO, or a Clinic Plan for most of your medical care.

- You do not have to go to your Sponsor Doctor for chiropractic, dental, family planning clinic, hearing, podiatric, and most vision services.
- You do not have to go to your HMO or Clinic Plan for dental services.

When you need medical care, you must call your Sponsor Doctor, HMO, or Clinic Plan. The name and telephone number of the Sponsor Doctor, HMO, or Clinic Plan will be printed on your Medicaid card.

If you need emergency treatment (for example, because you were in a car accident), and a delay in treatment could result in permanent harm or loss of life, you may go to the hospital emergency room. Since the name and telephone number of your Sponsor Doctor, HMO, or Clinic Plan will be on your Medicaid card, the hospital will call them, if necessary.

If you are unhappy with your Sponsor Doctor, you may change to another Sponsor Doctor, an HMO, or Clinic Plan by calling the Medicaid Sponsor Office at 256-9344. If you are unhappy with your HMO or Clinic Plan, you must contact your HMO or Clinic Plan to disenroll. You will have to choose a Sponsor Doctor, another HMO, or another Clinic Plan.

SPECIAL NOTE:

If you enroll with a Sponsor Doctor you will receive more information from Medicaid about the Medicaid Sponsor Plan. If the doctor you chose is not enrolled as a Sponsor Doctor, Medicaid will contact you to select another doctor, an HMO, or a Clinic Plan.

If you enroll in an HMO or Clinic Plan, the HMO or Clinic Plan will send you more information when you enroll.

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY
Michigan Department of Social Services

INSTRUCTIONS:

- Under Medicaid, you must enroll in the Medicaid Sponsor Plan, an HMO, or a Clinic Plan for all your medical care. READ THE FRONT SHEET OF THIS FORM FOR INFORMATION ON ALL THREE PLANS. Call 256 9344 if you need more information.
- Your family may enroll with different doctors under the Medicaid Sponsor Plan.
- If you choose an HMO or a Clinic Plan, all family members must enroll in the same HMO or Clinic Plan.
- Complete Section I below if you want to enroll in the Medicaid Sponsor Plan or a Clinic Plan for your family's medical care, OR
- Complete Section II below if you want to enroll in an HMO for your family's medical care.
- It is very important that you enter each recipient ID Number from your Medicaid card. If you do not have a Medicaid card, leave the Recipient ID Number box blank.
- After you complete this form, sign your name below and return this form to your caseworker.

Case Name				
Case Number				Date
County	District	Unit	Worker	

SECTION I: I want to enroll in the Medicaid Sponsor Plan or a Clinic Plan. If you go to a clinic, select a doctor from that clinic. Do NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

SECTION II: I want to enroll in an HMO.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	Enter the Name of the HMO	DSS Use Only	HMO Address	DSS Use Only

Client Address	Phone	SIGN HERE 	Client's Signature
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MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY

Michigan Department of Social Services

INSTRUCTIONS:

- Under Medicaid, you must enroll in the Medicaid Sponsor Plan, an HMO, or a Clinic Plan for all your medical care. READ THE FRONT SHEET OF THIS FORM FOR INFORMATION ON ALL THREE PLANS. Call 256-9344 if you need more information.
- Your family may enroll with different doctors under the Medicaid Sponsor Plan.
- If you choose an HMO or a Clinic Plan, all family members must enroll in the same HMO or Clinic Plan.
- Complete Section I below if you want to enroll in the Medicaid Sponsor Plan or a Clinic Plan for your family's medical care, OR
- Complete Section II below if you want to enroll in an HMO for your family's medical care.
- It is very important that you enter each recipient ID Number from your Medicaid card. If you do not have a Medicaid card, leave the Recipient ID Number box blank.
- After you complete this form, sign your name below and return this form to your caseworker.

Case Name				
Case Number				Date
County	District	Unit	Worker	

SECTION I: I want to enroll in the Medicaid Sponsor Plan or a Clinic Plan. If you go to a clinic, select a doctor from that clinic. Do NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

SECTION II: I want to enroll in an HMO.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	Enter the Name of the HMO	DSS Use Only	HMO Address	DSS Use Only

Client Address	Phone	SIGN HERE	Client's Signature
----------------	-------	--------------	--------------------

DSS-1336 (10-83)

Caseworker: Send completed form in ID mail to: Physician Primary Sponsor Plan Office
Medical Services Administration
Department of Social Services

If You Have Questions:

- Ask me or a member of my staff.
- Call the Medicaid Sponsor Office at 256-9344 (weekdays, 8:00-5:00), or
- Write to the Medicaid Sponsor Plan, Michigan Department of Social Services, P.O. Box 30037, Lansing, Michigan 48909.



Michigan State Medical Society

Michigan Department of
Social ServicesMichigan Association
of Obstetricians, Gynecologists
and Surgeons

MAKE THE CHOICE THAT IS BEST FOR YOU. Your health care is important to you and me. I will help you in any way that I can.

DSS Publication 489.2-80

**BUSINESS REPLY MAIL**

FIRST CLASS PERMIT NO 1312 LANSING, MI

POSTAGE WILL BE PAID BY

Medicaid Sponsor Plan
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



You can
enroll as
my patient

MAIL TO:
MEDICAID SPONSOR PLAN
P.O. BOX 30037
LANSING, MI 48909

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